MEDICARE B Update!

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

# In this issue...

FIRST COAST SERVICE OPTIONS INC.

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## Features



CMS
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The *Medicare B Update!* should be shared with all health care practitioners and managerial members of the provider/supplier staff. Publications issued beginning in 1997 are available at no cost from our provider education websites which may be accessed at: *http://medicare.fcso.com/*.

Routing Suggestions:

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The *Medicare B Update!* is published monthly by First Coast Service Options Inc. (FCSO) Provider Outreach and Education Division, to provide timely and useful information to Medicare Part B providers.

Questions concerning this publication or its contents may be faxed to 1-904-361-0723.




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# THE FCSO MEDICARE B UPDATE!

## About the FCSO *Medicare B Update!*

The *Medicare B Update!* is a comprehensive publication developed by First Coast Service Options Inc. (FCSO) for Part B providers in Florida, Puerto Rico, and U.S. Virgin Islands.

The Provider Outreach & Education Publications team distributes the *Medicare B Update!* on a monthly basis.

Important notifications that require communication in between publications will be posted to the FCSO Medicare provider education website, *http://medicare.fcso.com*. In some cases, additional unscheduled special issues may be posted.

### Who receives the *Update?*

Anyone may view, print, or download the *Update!* from our provider education Web site(s). Providers who cannot obtain the *Update!* from the Internet are required to register with us to receive a complimentary hardcopy or CD-ROM.

Distribution of the *Update!* in hardcopy or CD-ROM format is limited to individual providers and professional association (PA) groups who have billed at least one Part B claim to FCSO Medicare for processing during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, *if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed registration form to us*. Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription in hardcopy or CD-ROM format (see order form in the back of this issue). All issues published since 1997 may be downloaded from the Internet, free of charge.

We use the same mailing address for *all* correspondence, and cannot designate that the *Update!* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

### Publication format

The *Update!* is arranged into distinct sections.

Following the table of contents, an administrative information section, the *Update!* content information is categorized as follows.

- The **claims** section provides claim submission requirements and tips.
- The **coverage/reimbursement** section discusses specific *CPT* and HCPCS procedure codes. It is arranged by *categories* (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.
- The section pertaining to **electronic data interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **local coverage determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **general information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.

In addition to the above, other sections include:

- **Educational resources**, and
- **Addresses,** and **phone numbers**, and **websites** for Florida and the U.S. Virgin Islands.

### The *Medicare B Update!* represents formal notice of coverage policies

Articles included in each Update! represent formal notice that specific coverage policies either have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

## Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the Quarterly Provider Update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries.

Providers may access the Quarterly Provider Update by going to the CMS website at *http://www.cms.gov/QuarterlyProviderUpdates/*.

Providers may join the CMS-QPU listserv to ensure timely notification of all additions to the QPU.

## Advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient. For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

### Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the CMS-R131form as part of the Beneficiary Notices Initiative (BNI) The ABNs are designed to be beneficiary-friendly, readable and understandable, with patient options clearly defined.

There are two ABN forms - the General Use form (CMS-R-131G) and the Laboratory Tests form (CMS-R-131L). Both are standard forms that *may not be modified*; however, both contain customizable boxes for the individual requirements of users. Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found at *http://www.cms.gov/BNI/01_overview.asp#TopOfPage.*

**Note:** Beginning March 3, 2008, providers (including independent laboratories), physicians, practitioners, and suppliers may use the revised ABN (CMS-R-131 [03/08]) for all situations where Medicare payment is expected to be denied. The revised ABN replaces the existing ABN-G (CMS-R-131G), ABN-L (CMS-R-131L), and NEMB (CMS-20007). Beginning March 1, 2009, the ABN-G and ABN-L will no longer be valid. Additional information is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM6136.pdf*.

### ABN modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier **GA** (waiver of liability statement on file) or **GZ** (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier **GA** in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier **GZ** may be used in cases where a signed ABN is *not* obtained from the patient; however, when modifier **GZ** is billed, the provider assumes financial responsibility if the service or item is denied.

## GA modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier **GA** (wavier of liability statement on file).

Failure to report modifier **GA** in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

**Nonassigned** claims containing the modifier GA in which the patient has been found liable **must** have the patient's ***written consent*** for an appeal. Refer to the Address, Phone Numbers, and Websites section of this publication for the address in which to send written appeals requests.

**Find out first: Subscribe to FCSO eNews**

One of the secrets to achieving success as a Medicare provider is access to the right information at the right time. Subscribe to First Coast Service Options eNews, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

# CLAIMS

## Beneficiary-submitted claims

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.*

### Provider types affected

All physicians, providers, and suppliers submitting claims to Medicare contractors (carriers and A/B Medicare administrative contractors [MAC]) for services provided to Medicare beneficiaries are affected by this issue.

### Provider action needed

This article, based on change request (CR) 6874, clarifies instructions for processing claims by carriers and A/B MACs that are submitted by Medicare beneficiaries. All providers and suppliers are required to enroll in the Medicare program in order to receive payment. In addition, Section 1848 (g)(4)(A) of the Social Security Act requires all providers and suppliers submit claims for services rendered to Medicare beneficiaries. The current manual requirement instructs Medicare contractors how to process claims submitted by Medicare beneficiaries when the provider or supplier refuses to submit claims for services rendered and/or refuses to enroll in Medicare.

Medicare contractors will also provide education to the Medicare beneficiaries on how to submit complete claims, including all supporting documentation. Please inform your billing staffs of these instructions. **These requirements apply to all claims received on or after November 29, 2010, without regard to the date of service.**

**Note:** These instructions do not apply to foreign claims or durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) claims.

### Background

Medicare contractors will:

1) Process beneficiary-submitted claims for services that are not covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services; see 42 CFR 411.15 for details at *http://edocket.access.gpo.gov/cfr_2002/octqtr/42cfr411.15.htm*), in accordance with its normal processing procedures.

2) Process beneficiary-submitted claims for services that are covered by Medicare when the beneficiary has submitted a complete claim on CMS-1490S, which is available at *http://www.cms.gov/cmsforms/downloads/cms1490s-english.pdf*, and all supporting documentation associated with the claim, including an itemized bill with the following information:

   - Date of service
   - Place of service
   - Description of illness or injury
   - Description of each surgical or medical service or supply furnished
   - Charge for each service
   - The doctor's or supplier's name and address, and
   - The provider or supplier's national provider identifier (NPI).

Since there is no place on CMS-1490S to insert a provider or supplier's NPI, claims submitted by the beneficiary without the provider or supplier's NPI will not be considered incomplete. The contractor will use the NPI registry to locate the provider or supplier's NPI. If the contractor determines that the provider or supplier was not a Medicare enrolled provider with a valid NPI, contractors will follow previously established procedures in order for the claim to be processed and adjudicated through the claims processing system. If an incomplete claim or a claim containing invalid information is submitted, the contractor will return the claim as incomplete with an appropriate letter to the beneficiary that communicates the specific items listed above which were missing or invalid.

3) When returning a beneficiary-submitted claim (CMS-1490S) for a Medicare-covered service because the claim is not complete or contains invalid information, the contractor will retain the CMS-1490S and supporting documentation for purposes of the timely filing rules in the event that the beneficiary resubmits the claim.

When returning a beneficiary-submitted claim, the contractor will also inform the beneficiary, by letter, that the provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable), and that in order to submit the claim, the provider must enroll in the Medicare program. In addition, contractors should encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program. If a beneficiary receives services from a provider or supplier that refuses to submit a claim on the beneficiary's behalf (for services that would otherwise be payable by Medicare), and/or refused to enroll in Medicare, the beneficiary should:

1) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare, and

2) Submit a complete CMS-1490S with all supporting documentation.

Medicare contractors will process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider's or supplier's refusal to submit the claim and/or enroll in Medicare. The only exception would be for sanctioned and opt-out providers. Payment may only be made on the first claim submitted for services provided by an excluded/sanctioned or opt-out provider. No further payments will be made for services rendered by such providers after the first claim is paid.

***Beneficiary-submitted claims (continued)***

Contractors will maintain documentation of beneficiary complaints involving violations of the mandatory claims submission policy and a list of the top 50 violators, by state, of the mandatory claim submission policy.

### Additional information

If you have questions, please contact your Medicare carrier and/or MAC at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*. The official instruction, CR 6874, issued to your Medicare carrier and/or MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2031CP.pdf*.

MLN Matters® Number: MM6874
Related Change Request (CR) #: 6874
Related CR Release Date: August 20, 2010
Effective Date: November 29, 2010
Related CR Transmittal #: R2031CP
Implementation Date: November 29, 2010



## October update of correct coding initiative edits

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.*

### Provider types affected

Physicians and providers submitting claims to Medicare carriers and/or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries are impacted by this issue.

### Provider action needed

This article is based on change request (CR) 7081, which provides a reminder for physicians to take note of the quarterly updates to the correct coding initiative (CCI) edits. The last quarterly release of the edit module was issued in July 2010.

### Background

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The coding policies developed are based on coding conventions defined in the:

- American Medical Association's (AMA's) Current Procedural Terminology (CPT) Manual
- National and local policies and edits
- Coding guidelines developed by national societies
- Analysis of standard medical and surgical practice, and by
- Review of current coding practice.

The latest package of CCI edits, version 16.3, is effective October 1, 2010, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in the following two tables:

- Column 1/ Column 2 correct coding edits, and
- Mutually exclusive code (MEC) edits.

Additional information about CCI, including the current CCI and MEC edits, is available at *http://www.cms.gov/NationalCorrectCodInitEd*.

### Additional Information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which is available at *http://www.cms.gov/manuals/downloads/clm104c23.pdf*. The official instruction (CR 7081) issued to your carrier or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2036CP.pdf*.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7081
Related Change Request (CR) #: 7081
Related CR Release Date: August 27, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R2036CP
Implementation Date: October 4, 2010

## Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on March 1, 2010, must be paid before the end of business on March 31, 2010.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department Web page *http://fms.treas.gov/prompt/rates.html* for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

**The new rate of 3.125 percent is in effect through December 31, 2010.**

Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment (Part A claims only)
- Claims requesting anticipated payments under the home health prospective payment system (Part A claims only).

**Note:** The Medicare contractor reports the amount of interest on each claim on the remittance advice to the provider when interest payments are applicable.

Source: Publication 100-04, Chapter 1, Section 80.2.2



### Try our E/M interactive worksheet

First Coast Service Options (FCSO) Inc. is proud of its exclusive E/M interactive worksheet, available at *http://medicare.fcso.com/EM/165590.asp*. This resource was developed to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit. This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders. After you've tried the E/M interactive worksheet, send us your thoughts of this resource through our Web site feedback form, available at *http://medicare.fcso.com/Feedback/160958.asp*.

# Ambulatory Surgical Center

## October 2010 update to the ambulatory surgical center payment system

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.*

### Provider types affected

This article is for ambulatory surgical centers (ASCs), who submit claims to Medicare administrative contractors (MACs) and carriers, for services provided to Medicare beneficiaries paid under the ASC payment system.

### Provider action needed

This article is based on change request (CR) 7147 which describes changes to, and billing instructions for, payment policies implemented in the October 2010 ASC update. CR 7147 provides information on one newly created pass-through device Healthcare Common Procedure Coding System (HCPCS) code, five newly created drug HCPCS codes, and six newly created HCPCS codes describing imaging services that will be added to the ASC list of covered ancillary services effective October 1, 2010. Be sure your billing staff is aware of these changes.

### Background

Final policy under the revised ASC payment system, as set forth in the Medicare program; revised payment system policies for services furnished in ambulatory surgical centers (ASCs), beginning in CY 2008 (72 FR 42470), requires that ASC payment rates for covered separately payable drugs and biologicals be consistent with the payment rates under the Medicare hospital outpatient prospective payment system (OPPS). Those rates are updated quarterly.

The key updates effective on October 1, 2010, are as follows:

**New HCPCS codes for drugs and biologicals separately payable under the ASC payment system, effective October 1, 2010**

Five new HCPCS codes have been created for drugs that are payable as covered ancillary services for dates of service on and after October 1, 2010. The new HCPCS codes, the short descriptors, the long descriptors, and payment indicators are identified in Table 1.

The new separately payable drug and biological codes and their payment rates are included in the October 2010 ASC DRUG file.

**Table 1 – New drugs and biologicals separately payable under the ASC payment system effective October 1, 2010**

| HCPCS code | Long descriptor | Short descriptor | Payment indicator effective 10/01/10 |
|---|---|---|---|
| C9269 | Injection, C-1 esterase inhibitor (human), Berinert, 10 units | C-1 esterase, berinert | K2 |
| C9270 | Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg | Gammaplex IVIG | K2 |
| C9271 | Injection, velaglucerase alfa, 100 units | Velaglucerase alfa | K2 |
| C9272 | Injection, denosumab, 1 mg | Inj, denosumab | K2 |
| C9273 | Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF in 250 mL of Lactated Ringer's, including eukapheresis and all other preparatory procedures, per infusion | Sipuleucel-T, per infusion | K2 |

**Supplemental information for HCPCS code C9273**

The Centers for Medicare & Medicaid Services (CMS) has opened a national coverage determination (NCD) analysis for HCPCS code C9273, Provenge (Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF in 250mL of Lactated Ringer's, including leukapheresis and all other preparatory procedures, per infusion). A final decision on coverage is forthcoming in 2011. As with other drugs and biologicals, at this time, local carriers and MACs will retain the discretion to make individual claim determinations for Provenge based on the medical necessity of the service(s) being provided.

Additionally, CMS clarifies that the language given in the long descriptor of Provenge states that "all other preparatory procedures" refers to the transportation process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, subsequently sending the immune cells to the manufacturing facility, and then transporting the immune cells back to the site of service to be administered to the patient.

**Updated payment rate for *CPT* code *90476* effective April 1, 2010, through June 30, 2010**

The payment rate for one *CPT* code was incorrect in the April 2010 ASC DRUG file. The *CPT* code is *90476* (Adenovirus vaccine, type 4). The corrected payment rate is $72.17 with an ASC payment indicator (PI) of K2. The corrected

***October 2010 update to the ambulatory surgical center payment system (continued)***

code has been included in the revised April 2010 ASC DRUG file effective for services furnished on April 1, 2010, through implementation of the July 2010 update. Suppliers who think they may have received an incorrect payment between April 1, 2010, and June 30, 2010, may request contractor adjustment of the previously processed claims.

**Updated payment rates for certain HCPCS codes effective July 1, 2010, through September 30, 2010**

The payment rates for two HCPCS codes were incorrect in the July 2010 ASC DRUG file. The corrected payment rates are listed in Table 2 and have been included in the revised July 2010 ASC DRUG file effective for services furnished on July 1, 2010, through implementation of the October 2010 update. Suppliers who think they may have received an incorrect payment between July 1, 2010, and September 30, 2010, may request contractor adjustment of the previously processed claims.

**Table 2 – Updated payment rates for certain HCPCS codes effective July 1, 2010, through September 30, 2010**

| HCPCS code | Short descriptor | ASC payment rate | ASC PI |
|---|---|---|---|
| J9264 | Paclitaxel protein bound | $9.22 | K2 |
| C9268 | Capsaicin patch | $25.55 | K2 |

**Payment for vaccine *CPT* code *90670* effective April 1, 2010**

*CPT* code *90670* (*Pneumococcal conjugate vaccine, 13 valent, for intramuscular use*) was erroneously assigned ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate) in the July 2010 ASC update (CR 7008), effective April 1, 2010. Effective April 1, 2010, the payment for *CPT* code *90670* will change from ASC PI=K2 to ASC PI=L1 (Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made). As a result, *CPT* code *90670* does not appear in the revised April 2010 and revised July 2010 ASC DRUG files.

**Payment for vaccine *CPT* code *90662***

*CPT* code *90662* (**Long Descriptor***: Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use*; **Short Descriptor:** Flu vacc prsv free inc antig) has been assigned ASC PI=Y5. However, 90662 received approval from the Food and Drug Administration (FDA) on December 23, 2009. Therefore, effective December 23, 2009, *CPT* code *90662* is assigned ASC PI=L1 (Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made).

**New device pass-through category**

Additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the outpatient prospective payment system (OPPS). Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

The OPPS has established one new pass-through device category as of October 1, 2010. The ASC payment system is also establishing the same device pass-through code for separate payment effective October 1, 2010. CMS has determined that it is not able to identify a portion of the OPPS procedure payment amount associated with the cost of the device; therefore, CMS will not reduce the ASC procedure payment to remove the costs of related predecessor devices packaged into the base procedure's OPPS payment weight. Table 3 provides a listing of new ASC coding and payment information concerning the new device category for transitional pass-through payment. HCPCS code C1749 is assigned ASC PI=J7 (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced).

**Table 3 – New ASC device pass-through HCPCS code effective October 1, 2010**

| HCPCS | Short descriptor | Long descriptor | ASC PI |
|---|---|---|---|
| C1749 | Endo, colon, retro imaging | Endoscope, retrograde imaging/illumination colonoscope device (implantable) | J7 |

**Coding and payment for magnetic resonance angiography (MRA)**

Effective for claims with dates of service on and after June 3, 2010, CMS permits local Medicare contractors to cover (or not cover) all indications of MRA that are not specifically nationally covered or nationally noncovered. CMS has created the six level II HCPCS codes in Table 4 to allow ASCs to bill for certain MRA services that were previously noncovered but may now be covered at local Medicare contractor discretion. These HCPCS codes are assigned ASC PI=Z2 (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight) with the update to the Medicare physician fee schedule authorized for June 1 through November 30, 2010, under the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010. The six level II HCPCS codes must be used in place of existing *CPT* codes for the previously noncovered MRA procedures due to a statutory requirement that the OPPS provide payment for imaging services provided with contrast and without contrast through separate payment groups. Specifically, HCPCS codes C8931, C8932, and C8933 replace *CPT* code *72159* (*Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)*), while HCPCS codes C8934, C8935, and C8936 replace *CPT* code *73225* (*Magnetic resonance angiography, upper extremity, with or without contrast material(s)*).

***October 2010 update to the ambulatory surgical center payment system (continued)***

Further information on billing and coverage for MRA is available to contractors in Transmittal 123 (CR 7040), issued July 9, 2010. A related *MLN Matters*® article is available for that CR at *http://www.cms.gov/MLNMattersArticles/downloads/MM7040.pdf*.

**Table 4 – Carrier determination MRA codes effective June 3, 2010**

| HCPCS code | Long descriptor | Short descriptor | Payment indicator effective 06/03/10 |
|---|---|---|---|
| C8931 | Magnetic resonance angiography with contrast, spinal canal and contents | MRA, w/dye, spinal canal | Z2 |
| C8932 | Magnetic resonance angiography without contrast, spinal canal and contents | MRA, w/o dye, spinal canal | Z2 |
| C8933 | Magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents | MRA, w/o & w/dye, spinal canal | Z2 |
| C8934 | Magnetic resonance angiography with contrast, upper extremity | MRA, w/dye, upper extremity | Z2 |
| C8935 | Magnetic resonance angiography without contrast, upper extremity | MRA, w/o dye, upper extremity | Z2 |
| C8936 | Magnetic resonance angiography without contrast followed by with contrast, upper extremity | MRA, w/o dye, & w/ dye, upper extremity | Z2 |

**Coverage determinations**

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the ASC payment system does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Carriers/Medicare administrative contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, carriers/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

## Additional information

The official instruction, CR 7147 issued to your carrier and MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2045CP.pdf*.

If you have any questions, please contact your carrier and MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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Related CR Transmittal #: R2045CP
Implementation Date: October 4, 2010

# Audiology

## Revisions and re-issuance of audiology policies

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.*

**Note:** This article was revised on September 7, 2010, to reflect revisions to change request (CR) 6447, issued September 3. As a result, the article reflects the revised effective and implementation dates, CR release date, transmittal numbers, and Web addresses for accessing the transmittals. In addition, the remittance advice remark code used when Medicare will not pay for services performed by audiologists and billed under the NPI of a physician has been corrected to be consistent with the revised CR. All other information is the same. This information was previously published in the August 2010 *Medicare B Update!* pages 7-9.

### Provider types affected

This article is for physicians, nonphysician practitioners, audiologists, and speech-language pathologists submitting claims to Medicare administrative contractors (A/B MACs), carriers and fiscal intermediaries (FIs) for services provided to hearing impaired Medicare beneficiaries.

### Provider action needed

This article is based on CR 6447. The Centers for Medicare & Medicaid Services (CMS) issued CR 6447 to respond to provider requests for clarification of some of the language in CR 5717 and CR 6061. Special attention is given to clarifying policy concerning services incident to physician services that are paid under the Medicare physician fee schedule (MPFS). See the *Key Points* section for the clarifications provided by CR 6447.

### Background

Key parts of the clarified policy are in the revised Chapter 12, Section 30.3 of the *Medicare Claims Processing Manual* and in Chapter 15, Section 80.3 of the *Medicare Benefit Policy Manual*. These revised manual sections are attached to CR 6447. As mentioned in these revised sections of the manuals and per Section 1861 (ll) (3) of the Social Security Act, "audiology services" are defined as such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under state law (or the state regulatory mechanism provided by state law), as would otherwise by covered if furnished by a physician. These hearing and balance assessment services are termed "audiology services," regardless of whether they are furnished by an audiologist, physician, nonphysician practitioner (NPP), or hospital.

Because audiology services are diagnostic tests, when furnished in an office or hospital outpatient department, they must be furnished by or under the appropriate level of supervision of a physician as established in 42 CFR 410.32(b)(1) and 410.28(e). If not personally furnished by a physician, audiologist, or NPP, audiology services must be performed under direct physician supervision. As specified in 42 CFR 410.32(b)(2)(ii) or (v), respectively, these services are excepted from physician supervision when they are personally furnished by a qualified audiologist or performed by a nurse practitioner or clinical nurse specialist authorized to perform the tests under applicable state laws.

**Note:** References to technicians in CR 6447 and this article apply also to other qualified clinical staff. The qualifications for technicians vary locally and may also depend on the type of test, the patient, and the level of participation of the physician who is directly supervising the test. Therefore, an individual must meet qualifications appropriate to the service furnished as determined by the Medicare contractor to whom the claim is billed. If it is necessary to determine whether the individual who furnished the labor for appropriate audiology services is qualified, contractors may request verification of any relevant education and training that has been completed by the technician, which shall be available in the records of the clinic or facility.

Audiology services, like all other services, should be reported under the most specific HCPCS code that describes the service that was furnished and in accordance with all *CPT* guidance and Medicare national and local contractor instructions.

See the CMS website at *http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp* for a listing of all *CPT* codes for audiology services. For information concerning codes that are not on the list, and which codes may be billed when furnished by technicians, contractors shall provide guidance. The MPFS at *http://www.cms.gov/PFSlookup/* allows you to search pricing amounts, various payment policy indicators, and other MPFS data.

### Qualifications discussion

The individuals who furnish audiology services in all settings must be qualified to furnish those services. The qualifications of the individual performing the services must be consistent with the number, type and complexity of the tests, the abilities of the individual, and the patient's ability to interact to produce valid and reliable results. The physician who supervises and bills for the service is responsible for assuring the qualifications of the technician, if applicable, are appropriate to the test.

When a professional personally furnishes an audiology service, that individual must interact with the patient to provide professional skills and be directly involved in decision-making and clinical judgment during the test.

The skills required when professionals furnish audiology services for payment under the MPFS are masters or doctoral level skills that involve clinical judgment or assessment and specialized knowledge and ability including,

***Revisions and re-issuance of audiology policies (continued)***

but not limited to, knowledge of anatomy and physiology, neurology, psychology, physics, psychometrics, and interpersonal communication. The interactions of these knowledge bases are required to attain the clinical expertise for audiology tests. Also required are skills to administer valid and reliable tests safely, especially when they involve stimulating the auditory nerve and testing complex brain functions.

Diagnostic audiology services also require skills and judgment to administer and modify tests, to make informed interpretations about the causes and implications of the test results in the context of the history and presenting complaints, and to provide both objective results and professional knowledge to the patient and to the ordering physician.

Examples include, but are not limited to:

- Comparison or consideration of the anatomical or physiological implications of test results or patient responsiveness to stimuli during the test
- Development and modification of the test battery and test protocols
- Clinical judgment, assessment, evaluation, and decision-making
- Interpretation and reporting observations, in addition to the objective data, that may influence interpretation of the test outcomes
- Tests related to implantation of auditory prosthetic devices, central auditory processing, contralateral masking, and/or
- Tests to identify central auditory processing disorders, tinnitus, or nonorganic hearing loss

## Key points of CR 6447

- For claims with dates of service on or after October 1, 2008, audiologists are required to be enrolled in the Medicare program and use their national provider identifier (NPI) on all claims for services they render in office settings.
- For audiologists who are enrolled and bill independently for services they render, the audiologist's NPI is required on all claims they submit.

For example, in offices and private practice settings, an enrolled audiologist shall use his or her own NPI in the rendering loop to bill under the MPFS for the services the audiologist furnished. If an enrolled audiologist furnishing services to hospital outpatients reassigns his/her benefits to the hospital, the hospital may bill the Medicare contractor for the professional services of the audiologist under the MPFS using the NPI of the audiologist. If an audiologist is employed by a hospital but is not enrolled in Medicare, the only payment for a hospital outpatient audiology service that can be made is the payment to the hospital for its facility services under the hospital outpatient prospective payment system (OPPS) or other applicable hospital payment system. No payment can be made under the MPFS for professional services of an audiologist who is not enrolled.

- Audiology services may be furnished and billed by audiologists and, when these services are furnished by an audiologist, no physician supervision is required.
- When a physician or supplier furnishes a service that is covered by Medicare, then it is subject to the mandatory claim submission provisions of Section 1848(g)(4) of the Social Security Act. Therefore, if an audiologist charges or attempts to charge a beneficiary any remuneration for a service that is covered by Medicare, then the audiologist must submit a claim to Medicare.
- Medicare pays for diagnostic audiological tests under the MPFS when they meet the requirements of audiology services as shown in Chapter 15, Section 80.3 of the *Medicare Benefit Policy Manual* as attached to CR 6447.
- For claims with dates of service on or after October 1, 2008, the NPI of the enrolled audiologist is required on claims in the appropriate rendering and billing fields.
- Medicare will not pay for services performed by audiologists and billed under the NPI of a physician. In denying such claims, Medicare will use:
  - Claim adjustment reason code (CARC)170 (Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.); and
  - Remittance advice remark code (RARC) N290 (Missing/incomplete/invalid rendering provider primary identifier.)
- Medicare will not pay for an audiological test under the MPFS if the test was performed by a technician under the direct supervision of a physician if the test requires professional skills. Such claims will be denied using CARC 170 (Payment is denied when performed/billed by this type of provider. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.).
- Medicare will not pay for audiological tests furnished by technicians unless the service is furnished under the direct supervision of a physician. In denying claims under this provision, Medicare will use:
  - CARC 185 (The rendering provider is not eligible to perform the service billed. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.), and
  - RARC M136 (Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.)
- Medicare will pay for the technical component (TC) of diagnostic tests that are not on the list of audiology services when those tests are furnished by audiologists under the designated level of physician supervision for the service and the audiologist is qualified to perform the service. (Once again, the list of audiology services is posted at *http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp*).
- Medicare will pay physicians and NPPs for treatment services furnished by audiologists incident to

***Revisions and re-issuance of audiology policies (continued)***

physicians' services when the services are not on the list of audiology services at *http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp* and are not "always" therapy services and the audiologist is qualified to perform the service.

- All audiological diagnostic tests must be documented with sufficient information so that Medicare contractors may determine that the services do qualify as an audiological diagnostic test.
- The interpretation and report shall be written in the medical record by the audiologist, physician, or NPP who personally furnished any audiology service, or by the physician who supervised the service. Technicians shall not interpret audiology services, but may record objective test results of those services they may furnish under direct physician supervision. Payment for the interpretation and report of the services is included in payment for all audiology services, and specifically in the professional component (PC), if the audiology service has a professional component/technical component split.
- When Medicare contractors review medical records of audiological diagnostic tests for payment under the MPFS, they will review the technician's qualifications to determine whether, under the unique circumstances of that test, a technician is qualified to furnish the test under the direct supervision of a physician.
- The PC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. (Note this is also true in the facility setting.) A physician or NPP may bill for the PC when the physician or NPP furnish the PC and an (unsupervised) audiologist furnishes and bills for the TC. The PC may not be billed if a technician furnishes the service. A physician or NPP may not bill for a PC service furnished by an audiologist.
- The TC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. Physicians may bill the TC for services furnished by technicians when the technician furnishes the service under the direct supervision of that physician. Audiologists and NPPs may not bill for the TC of the service when a technician furnishes the service, even if the technician is supervised by the NPP or audiologist.
- The "global" service is billed when both the PC and TC of a service are personally furnished by the same audiologist, physician, or NPP. The global service may also be billed by a physician, but not an audiologist or NPP, when a technician furnishes the TC of the service under direct physician supervision and that physician furnishes the PC, including the interpretation and report.
- Tests that have no appropriate *CPT* code may be reported under *CPT* code *92700* (*Unlisted otorhinolaryngological service or procedure*).
- Audiology services may not be billed when the place of service is a comprehensive outpatient rehabilitation facility (CORF) or a rehabilitation agency.
- The opt out law does not define "physician" or "practitioner" to include audiologists; therefore, they may not opt out of Medicare and provide services under private contracts.

## Additional information

There are two transmittals related to CR 6447, the official instruction issued to your Medicare A/B MAC, FI and/or carrier. The first modifies the *Medicare Benefit Policy Manual* and that transmittal is at *http://www.cms.gov/Transmittals/downloads/R132BP.pdf*. The other transmittal modifies the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Transmittals/downloads/R2044CP.pdf*. If you have questions, please contact your Medicare A/B MAC, FI or carrier at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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### Website survey

We would like to hear your comments and suggestions on the website through our survey. If you see our customer satisfaction survey pop up while you are browsing the Medicare site, please take a few minutes and fill it out. We want to know how well the entire site and specific site elements address your needs. As our site is constantly changing, we would appreciate your input every two months or so. It is your feedback that makes changes possible.

# Consolidated Billing

## Annual update of HCPCS codes used for SNF consolidated billing update

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.*

### Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries who are in a Part A covered skilled nursing facility (SNF) stay.

### Provider action needed

***Stop – impact to you***

This article is based on change request (CR) 7159 which provides the 2011 annual update of Healthcare Common Procedure Coding System (HCPCS) codes for SNF consolidated billing (CB) and how the updates affect edits in Medicare claims processing systems.

***Caution – what you need to know***

Physicians and providers are advised that, by the first week in December 2010, new code files will be posted at *http://www.cms.hhs.gov/SNFConsolidatedBilling/*. Note that this site will include new Excel® and PDF format files. It is important and necessary for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI/A/B MAC update listed at *http://www.cms.hhs.gov/SNFConsolidatedBilling/* in order to understand the major categories, including additional exclusions not driven by HCPCS codes.

***Go – what you need to do***

See the *Background* and *Additional information* sections of this article for further details regarding these changes.

### Background

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a noncovered stay. Changes to HCPCS codes and Medicare physician fee schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual* (Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs) which is available at *http://www.cms.gov/manuals/downloads/clm104c06.pdf*. These edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

### Additional information

The official instruction, CR 7159, issued to your carriers, DME MACs, FIs, and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2048CP.pdf*.

If you have any questions, please contact your carriers, DME MACs, FIs, or A/B MACs at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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## ESRD prospective payment system and consolidated billing

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.*

### Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for end-stage renal disease (ESRD) services provided to Medicare beneficiaries.

### Provider action needed

***Stop – impact to you***

This article is based on change request (CR) 7064 which announces the implementation of an (ESRD) bundled prospective payment system (PPS) effective January 1, 2011.

***Caution – what you need to know***

Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services. The ESRD PPS will provide a single payment to ESRD facilities, i.e., hospital-based providers of services and renal dialysis facilities, that will cover all the resources used in providing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home, drugs, biologicals, laboratory tests, training, and support services. The ESRD PPS provides ESRD facilities a four-year phase-in (transition) period under which they would receive a blend of the current payment methodology and the new ESRD PPS payment. In 2014, the payments will be based 100 percent on the ESRD PPS payment.

***ESRD prospective payment system and consolidated billing (continued)***

***Go – what you need to do***

Since the ESRD PPS is effective for services on or after January 1, 2011, it is important that providers not submit claims spanning dates of service in 2010 and 2011. ESRD facilities have the opportunity to make a one-time election to be excluded from the transition period and have their payment based entirely on the payment amount under the ESRD PPS as of January 1, 2011. Facilities wishing to exercise this option must do so on or before November 1, 2010. See the *Background* and *Additional information* sections of this article for further details regarding the ESRD PPS.

## Background

The Medicare Improvements for Patients and Providers Act (MIPPA); Section 153(b); see *http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331*) requires the Centers for Medicare & Medicaid services (CMS) to implement an ESRD bundled PPS effective January 1, 2011. Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services.

Specifically, the ESRD PPS combines payments for composite rate and separately billable services into a single base rate. The per dialysis treatment base rate for adult patients is subsequently adjusted to reflect differences in:

- Wage levels among the areas in which ESRD facilities are located
- Patient-level adjustments for case-mix
- An outlier adjustment (if applicable)
- Facility-level adjustments
- A training add-on (if applicable), and
- A budget neutrality adjustment during the transition period through 2013.

**Patient-level adjustments**

The patient-level adjustments are patient-specific case-mix adjusters that were developed from a two-equation regression analysis that encompasses composite rate and separately billable items and services. Included in the case-mix adjusters for adults are those variables that are currently used in basic case-mix adjusted composite payment system, that is, age, body surface area (BSA), and low body mass index (BMI). In addition to those adjusters that are currently used, the ESRD PPS will also incorporate adjustments for six co-morbidity categories and an adjustment for the onset of renal dialysis.

**Outlier adjustment**

ESRD facilities that are treating patients with unusually high resource requirements, as measured through their utilization of identified services beyond a specified threshold, will be entitled to outlier payments. Such payments are an additional payment beyond the otherwise applicable case-mix adjusted prospective payment amount.

ESRD outlier services are the following items and services that are included in the ESRD PPS bundle:

1. ESRD-related drugs and biologicals that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B
2. ESRD-related laboratory tests that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B
3. Medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B, and
4. Renal dialysis service drugs that were or would have been, prior to January 1, 2011, covered under Medicare Part D, notwithstanding the delayed implementation of ESRD-related oral-only drugs effective January 1, 2014.

**Note:** Services not included in the PPS that remain separately payable, including blood and blood processing, preventive vaccines, and telehealth services, are not considered outlier services.

**Facility-level adjustments**

The facility-level adjustments include adjusters to reflect urban and rural differences in area wage levels using an area wage index developed from core based statistical areas (CBSAs). The facility-level adjustments also include an adjuster for facilities treating a low-volume of dialysis treatments.

**Training add-on**

Facilities that are certified to furnish training services will receive a training add-on payment amount of $33.44, which is adjusted by the geographic area wage index to account for an hour of nursing time for each training treatment that is furnished. The training add-on applies to both peritoneal dialysis (PD) and hemodialysis (HD) training treatments.

**Adjustments specific to pediatric patients**

The pediatric model incorporates separate adjusters based on two age groups (<13, 13-17) and dialysis modality (hemodialysis, peritoneal dialysis). The per-treatment base rate as it applies to pediatric patients is the same base rate that applies for adult patients, which is also adjusted by the area wage index. However, due to the lack of statistical robustness, the base rate for pediatric patients is not adjusted by the same patient-level case-mix adjusters as for adult patients. Instead, the pediatric payment adjusters reflect the higher total payments for pediatric composite rate and separately billable services, compared to that of adult patients.

**Treatments furnished to pediatric patients**

- Can qualify for a training add-on payment (when applicable), and
- Are eligible for an outlier adjustment.

**Note:** Pediatric dialysis treatments are not eligible for the low-volume adjustment.

**ESRD PPS transition period**

The ESRD PPS provides ESRD facilities with a four year transition period under which they would receive a blend of payments under the prior case-mix adjusted composite payment system and the new ESRD PPS as noted in the following table:

The ESRD PPS four year transition period blended rate determination

***ESRD prospective payment system and consolidated billing (continued)***

| Calendar year | Blended rate |
|---|---|
| 2011 | 75 percent of the old payment methodology and 25 percent of new PPS payment |
| 2012 | 50 percent of the old payment methodology and 50 percent of the new PPS payment |
| 2013 | 25 percent of the old payment methodology and 75 percent of the new PPS payment |
| 2014 | 100 percent of the PPS payment |

For calendar year (CY) 2011, CMS will continue to update the basic case-mix composite payment system for purposes of determining the composite rate portion of the blended payment amount. CMS updated the composite payment rate, the drug add-on adjustment to the composite rate, the wage index adjustment, and the budget neutrality adjustment.

The ESRD PPS base rate is $229.63, which is applicable for both adult and pediatric ESRD patients effective January 1, 2011. This base rate will be wage adjusted as mentioned above where:

- The labor-related share of the base rate from the ESRD PPS market basket is 0.41737, and
- The non labor-related share of the base rate is $133.79 ((229.63 X (1 - 0.41737) = $133.79).

During the transition, the labor-related share of the case-mix adjusted composite payment system will remain 0.53711. The payment rate for a dialysis treatment is determined by wage adjusting the base rate and then applying any applicable:

- Patient-level adjustments
- Outlier adjustments
- Facility-level adjustments, and
- Training add-on payments (adjusted for area wage levels)

Once the payment rate for the dialysis treatment is determined, the last item in the computation to determine the final payment rate is the application of the transition budget neutrality factor of .969, that is, a 3.1 percent reduction.

The ESRD PRICER will provide the payment for existing composite rate, the new ESRD PPS payment rate, and the outlier payment (when applicable). These reimbursement amounts must be blended during a transition period for all ESRD facilities except those facilities opting out of the transition and electing to be paid 100 percent of the payment amount under the new ESRD PPS.

**Note:** Providers wishing to opt out of the transition period blended rate must notify their Medicare contractor on or before November 1, 2010. Providers shall not submit claims spanning date of service in 2010 and 2011**.**

**Three new adjustments applicable to the adult rate**
**Comorbid adjustments**: The new ESRD PPS provides for three categories of chronic comorbid conditions and three categories for acute comorbid conditions. A single adjustment will be made to claims containing one or more of the comorbid conditions. The highest comorbid adjustment applicable will be applied to the claim. The acute comorbid adjustment may be paid no greater than four consecutive months for any reported acute comorbid condition, unless there is a reoccurrence of the condition. The three chronic comorbid categories eligible for a payment adjustment are:

- Hereditary hemolytic and sickle cell anemia
- Monoclonal gammopathy (in the absence of multiple myeloma), and
- Myelodysplastic syndrome.
- The three acute comorbid categories eligible for a payment adjustment are:
- Bacterial pneumonia
- Gastrointestinal bleeding, and
- Pericarditis.

**Onset of dialysis adjustment:** An adjustment will be made for patients that have Medicare ESRD coverage during their first four months of dialysis. This adjustment will be determined by the dialysis start date in Medicare's common working file as provided on the CMS form 2728, completed by the provider. When the onset of dialysis adjustment is provided, the claim is not entitled to a comorbid adjustment or a training adjustment.

**Low-volume facility adjustment:** Providers will receive an adjustment to their ESRD PPS rate when the facility furnished less than 4,000 treatments in each of the three years preceding the payment year and has not opened, closed, or received a new provider number due to a change in ownership during the three years preceding the payment year. The three years preceding treatment data should be reflected on the last two settled cost reports and the most recent must be filed. The provider must notify their Medicare contractor if they believe they are eligible for the low-volume adjustment.

**Change in processing home dialysis claims**

For claims with dates of service on or after January 1, 2011, the payment of home dialysis items and services furnished under method II, regardless of home treatment modality, are included in the ESRD PPS payment rate. Therefore, all home dialysis claims:

- Must be submitted by a renal dialysis facility, and
- Will be processed as method I claims.

**Note:** CR 7064 instructs the DME MACs to stop separate payment to suppliers for method II home dialysis items and services for claims with dates of service on or after January 1, 2011. Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7964) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the modifier AY.

**Consolidated billing**

CR 7064 provides an ESRD consolidated billing requirement for limited Part B services included in the

***ESRD prospective payment system and consolidated billing (continued)***

ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these lab services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted by the laboratory supplier or other provider with the new modifier AY to allow for separate payment outside of ESRD PPS. ESRD facilities billing for any labs or drugs will be considered part of the bundled PPS payment unless billed with the modifier AY. In addition, as noted above, Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7064) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the modifier AY.

**Other billing reminders**

- Note that with the ESRD PPS changes, Medicare systems will also reject any lines reporting revenue code 0880 as of January 1, 2011. These rejections will be made with remittance advice remark code (RARC) M81 (You are required to code to the highest level of specificity), and assign a group code of CO (provider liability) to such lines.
- Medicare will return claims to the provider with dates of service spanning 2010 and 2011.
- Telehealth services billed with HCPCS Q3014, preventive services covered by Medicare, and blood and blood services are exempt from the ESRD PPS and will be paid based on existing payment methodologies.
- When claims are received without the AY modifier for items and services that are not separately payable due to the ESRD PPS consolidated billing process, the claims will be returned with claim adjustment reason code (CARC) 109 (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.), RARC N538 (A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.), and assign group code CO.
- All 72x claims from method II facilities with condition code 74 will be treated as method I claims as of January 1, 2011. Effective that same date, Medicare will no longer enter Method selection forms data into its systems.
- Services included in the existing composite rate continue to not be reported on the claim unless they are clinical lab services subject to the 50/50 rule. The only additional data that must be reported on or after January 1, 2011 are any oral and other equivalent forms of injectable drugs identified as outlier services. Oral and other equivalent forms of injectable drugs should be reported with the revenue code 0250. The drug NDC code must be reported with quantity field reflecting the smallest available unit.
- Payment for ESRD-related Aranesp® and ESRD-related epoetin alfa (EPO) is included in the ESRD PPS for claims with dates of service on or after January 1, 2011.
- Effective January 1, 2011, Section 153b of the MIPPA requires that all ESRD-related drugs and biologicals are included in the ESRD PPS and must be billed by the renal dialysis facility.

## Additional information

The official instruction, CR 7064, issued to your carriers, DME MACs, FIs and/or A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2033CP.pdf*. Attached to CR 7064, you may find the following documents to be helpful:

- Attachment 3, which is a list of outlier services
- Attachment 4, which is a list of DME ESRD supply HCPCS codes used in for ESRD PPS consolidated billing edits
- Attachment 5, which contains a list of DME ESRD supply HCPCS codes that are NOT payable to DME suppliers
- Attachment 6, which is a list of laboratory CPT/HCPCS codes subject to ESRD consolidated billing
- Attachment 7, which lists the drug codes subject to ESRD consolidated billing, and
- Attachment 8, which lists by ICD-9-CM codes, the comorbid categories and diagnosis codes.

If you have any questions, please contact your carriers, DME MACs, FIs, and/or A/B MACs at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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# Drugs and Biologicals

## Important news about flu shot frequency

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.*

### Provider types affected

This article is for physicians, providers, and suppliers providing flu shot services to Medicare beneficiaries.

### What you need to know

This article provides important information to physicians and other providers regarding the frequency of allowable flu vaccinations for Medicare beneficiaries.

### Background

Effective for services furnished on or after May 1, 1993, the Medicare Part B program covers influenza virus vaccine and its administration when furnished in compliance with any applicable state law by any provider of services or any entity enrolled in the Medicare program. Typically, one vaccine is allowable per influenza virus season (once a year in the fall or winter). Medicare will pay for more than one influenza virus vaccination per influenza season if a physician determines and documents in the patient's medical record that the additional vaccination is reasonable and medically necessary. Medicare beneficiaries may receive the vaccine once each influenza season, paid by Medicare, without a physician's order and without the supervision of a physician. A patient could receive an influenza virus vaccine twice in a calendar year and Medicare will pay for both. For example, a beneficiary may receive an influenza virus vaccination in January 2010 and another influenza virus vaccination in November 2010.

### Medicare billing for flu vaccines

Because Medicare beneficiaries generally fall into a high-risk category, they are being encouraged to obtain the flu vaccine every flu season. Beneficiaries can receive a flu vaccine from any licensed physician or provider. However, for Medicare payment of the vaccine and its administration, beneficiaries should obtain their vaccinations from a Medicare-enrolled physician/provider.

If you are a Medicare-enrolled physician or provider (including centralized billers) and have the flu vaccine available, you must bill Medicare for the cost of the vaccination and its administration. Medicare beneficiaries do not pay any deductible or coinsurance. Please remember that Medicare allows for roster billing when you administer the flu vaccine to a number of beneficiaries at one location (e.g., a physician's office).

### Additional information

The specific rules to follow for roster billing may be found in Chapter 18, Section 10.3 of the *Medicare Claims Processing Manual* at *http://www.cms.gov/manuals/downloads/clm104c18.pdf*.

If you do not have the vaccine available, you should refer your patients to 1-800-MEDICARE (1-800-633-4227; TTY users should call 1-877-486-2048) or to *http://www.medicare.gov* where they can get the phone number for their state health department. Health departments throughout the United States are attempting to ensure that as many high-risk individuals as possible will get a flu vaccine.

MLN Matters Number: SE1026
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A



### Use the PDS report to improve your Medicare billing operations

Did you know that the Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Just access the PDS report through our convenient online portal, establish your account, and compare your billing patterns with those of similar providers during a specified billing period. This invaluable resource will help you proactively reduce billing errors by learning to avoid them before they occur. Would you like to find out more? Just visit our dedicated PDS page, where you'll find helpful simulations, a quick-start guide, and a helpful guide to teach you how to apply PDS results to your business needs.

# Discarded drugs and biologicals policy at contractor discretion

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.*

## Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], A/B Medicare administrative contractors [A/B MACs] and/or durable medical equipment Medicare administrative contractors [DME MACs] for drugs or biologicals administered to Medicare beneficiaries.

## Provider action needed

***Stop – impact to you***

This article is based on change request (CR) 7095 which is being issued in response to inquiries related to CR 6711 pertaining to the use of the modifier JW (drug or biological amount discarded/not administered to any patient) for discarded drugs and biologicals.

***Caution – what you need to know***

CR 7095 instructs that each Medicare contractor 1) has the individual discretion to determine whether the modifier JW is required for any claims with discarded drugs including the specific details regarding how the discarded drug information should be documented and applied on the claim; and 2) will notify their respective providers of such requirements associated with the use of the modifier JW.

***Go – what you need to do***

Your Medicare contractor will provide you with details concerning the use of the modifier JW for discarded drugs and biological. Be sure to follow those requirements.

## Background

Previously, the Centers for Medicare & Medicaid Services (CMS) issued CR 6711 (see the *MLN Matters*® article related to CR 6711 at *http://www.cms.gov/MLNMattersArticles/downloads/MM6711.pdf*) which updated the *Medicare Claims Processing Manual* (Chapter 17, Section 40) and provided policy on the appropriate use of the modifier JW (drug or biological amount discarded/not administered to any patient) for discarded drugs or biologicals. After issuing CR 6711, CMS received several inquiries from various providers regarding how the modifier JW is to be used for their Medicare Part B drug claims. CR 7095 is being issued in response to these inquiries, and it instructs that each Medicare contractor:

- Has the individual discretion to determine whether the modifier JW is required for any claims with discarded drugs including the specific details regarding how the discarded drug information should be documented and applied on the claim, and
- Will notify their respective providers of such requirements associated with the use of the modifier JW.

## Additional information

The official instruction, CR 7095, issued to your carrier, FI, A/B MAC, or DME MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R758OTN.pdf*.

If you have any questions, please contact your carrier, FI, A/B MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7095
Related Change Request (CR) #: 7095
Related CR Release Date: August 20, 2010
Effective Date: July 30, 2010
Related CR Transmittal #: R758OTN
Implementation Date: September 21, 2010



# Modifier JW for discarded drugs and biologicals not required

In response to inquiries related to change request 6711 pertaining to the use of the modifier JW, the Centers for Medicare & Medicaid Services (CMS) recently released CR 7095 (Discarded drugs and biologicals policy at contractor discretion), available at *http://www.cms.gov/Transmittals/downloads/R758OTN.pdf*. The purpose and intent of the CR is to reiterate to providers that contractors have the option to require or not require the modifier.

FCSO made the decision to not require the modifier JW (see article published on page 11 of the May 2008 *Medicare B Update!*).

Source: Publication 100-04, transmittal 758, change request 7095

# Laboratory/Pathology

## New waived tests

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.*

### Provider types affected

Clinical laboratories and providers submitting claims to Medicare contractors (carriers and Medicare administrative contractors [MACs]) for laboratory test services provided to Medicare beneficiaries are affected.

### Provider action needed

This article is based on change request (CR) 7084, which informs Medicare contractors of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Be sure your billing staffs are aware of the changes.

### Background

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that the Medicare and Medicaid programs only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed below are the latest tests approved by the FDA as waived tests under CLIA. The *Current Procedural Terminology* (*CPT*) codes for the following new tests must have the modifier QW, defined as CLIA waived test, to be recognized as a waived test. However, the test with *CPT* code *82962* does not require a QW modifier to be recognized as a waived test.

| CPT code | Effective date | Description |
|---|---|---|
| G0430 QW | January 1, 2010 | Noble Medical Inc. Split-Specimen Cup |
| *82274* QW<br>G0328 QW | March 1, 2010 | Inverness Medical Clearview iFOBT complete fecal occult blood test |
| *82010* QW<br>*82962* (no QW modifier needed) | March 2, 2010 | Nova Biomedical Nova Max plus glucose and B-Ketone Monitoring System |
| *83986* QW | April 15, 2010 | Common Sense Ltd. VS-SenseTest (qualitative) |
| *85610* QW | April 15, 2010 | CoaguSense self-test prothrombin time/INR monitoring system (prescription home use) |
| G0430 QW | April 21, 2010 | Redwood Toxicology Laboratory, Inc Reditest Freedom Cup |
| G0430 QW | April 21, 2010 | Noble Medical Inc. NOBLE 1 Step Cup (OTC) |
| G0430 QW | April 30, 2010 | Express Diagnostics, DrugCheck Waive Cup |
| G0430 QW | April 30, 2010 | Express Diagnostics International Inc. DrugCheck Waive multiple drug screen cups |
| *81003* QW | June 3, 2010 | Cole-Talyor Marketing Inc. CTI-120 urine strip analyzer |

Note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims processed prior to implementation of these changes. However, they will adjust such claims that you bring to their attention.

### Additional information

If you have questions, please contact your Medicare carrier and/or MAC at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The official instruction, CR 7084, issued to your Medicare carrier and/or MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2038CP.pdf*.

MLN Matters® Number: MM7084
Related Change Request (CR) #: 7084
Related CR Release Date: August 27, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R2038CP
Implementation Date: October 4, 2010

# General Coverage

## Change physician specialty code 12 to osteopathic manipulative medicine

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.*

### Provider types affected

This article is for physicians and providers submitting claims to Medicare contractors (carriers and/or Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries.

### What you need to know

Effective January 1, 2011, Medicare claims processing systems will be revised to change the name of physician specialty code 12 from osteopathic manipulative therapy to osteopathic manipulative medicine. Medicare's Provider Enrollment, Chain and Ownership System (PECOS) will also recognize physician specialty code 12 as a valid specialty code for osteopathic manipulative medicine.

### Additional information

The official instruction, CR 6890, issued to your carrier or MAC, regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2035CP.pdf*. If you have any questions, please contact your carrier, A/B MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6890
Related Change Request (CR) #: 6890
Related CR Release Date: August 27, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2035CP
Implementation Date: January 3, 2011

# Electronic Data Interchange

## Closing in on the target testing date of January 2011 for HIPAA version 5010

Health-care providers, health plans, clearinghouses and vendors should be finished with their internal testing of the HIPAA version 5010 electronic health-care transaction standards by the first recommended deadline for internal testing, December 31, 2010, and be ready to start testing with their external partners, beginning in January 2011, just about four months away.

Beginning January 2011, CMS' Medicare fee-for-service program will be ready to test HIPAA version 5010 transaction standards with its external partners, and other industry segments should be poised to follow suit.

This recommended external testing start date will give the industry adequate time to ensure that their HIPAA version 5010 transactions are being conducted correctly, in preparation for mandatory HIPAA version 5010 compliance by January 1, 2012.

Don't fall behind on this important testing process. Make sure you communicate with your external partners about your HIPAA version 5010 testing plans. Incorporate your HIPAA version 5010 testing messages into your existing communication vehicles, including website links, customer service encounters, etc., to let everyone know when you will be ready to start testing HIPAA version 5010 transactions with them.

### Keep up-to-date on version 5010 and ICD-10

Please visit *http://www.cms.gov/icd10/* for the latest news and sign up for HIPAA version 5010 and ICD-10 e-mail updates.

**HIPAA version 5010 and ICD-10 are coming. Will you be ready?**

**Note:** If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201008-37

## HIPAA version 5010 and D.0 national calls

Throughout the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) version 5010 and D.0 transaction standards, the Centers for Medicare & Medicare Services (CMS) will be hosting a series of national education calls that will inform the Medicare fee-for-service provider community of the steps that they need to take in order to be ready for implementation.

These calls will also give participants an opportunity to ask questions of Medicare subject matter experts.

Please bookmark this link *http://www.cms.gov/Versions5010andD0/V50/list.asp* to the new 5010/D.0 national calls Web page to stay current on upcoming calls and view materials from past calls.

**Keep up-to-date on HIPAA version 5010/D.0 and ICD-10.**

For the latest news and resources, please visit http*://www.cms.gov/Versions5010andD0* for version 5010 and *http://www.cms.gov/ICD10/* for ICD-10 information.

**Note:** If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201009-24

## Implementation of the PWK (paperwork) segment for X12N version 5010

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.*

### Provider types affected

This article is for physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare administrative contractors (MACs), durable medical equipment Medicare administrative contractors, and fiscal intermediaries (FIs) including regional home health intermediaries).

### Provider action needed

This article is based on change request (CR) 7041 which announces the implementation of the PWK (paperwork) segment for X12N version 5010. Be sure your billing staff is aware of these changes.

### Background

Since 2003, the Centers for Medicare & Medicaid Services (CMS) has believed that a complete Health Insurance Portability & Accountability Act of 1996 (HIPAA) implementation involves implementing the PWK (paperwork) segment. The PWK is a segment within the 837 Professional and Institutional electronic transactions. The PWK segment provides the "linkage" between electronic claims and additional documentation which is needed for claims adjudication. Although the PWK segment allows for an electronic submission of the additional documentation, this preliminary implementation will only allow for submission of additional documentation via mail and fax.

***Implementation of the PWK (paperwork) segment for X12N version 5010 (continued)***

The implementation of a dedicated PWK process, involving OCR/imaging technology, allows providers to continue using cost effective electronic data interchange (EDI) technology as well as providing cost savings for the Medicare program. Medicare contractors will be responsible for imaging, storage, and retrieval of the additional documentation for their claims examiners. Having the documentation available to claims examiners eliminates the need for costly automated development.

## Key points for Medicare billers

- Your Medicare contractor will implement the appropriate PWK fax/mail cover sheet for their line of business which must be used by trading partners when mailing or faxing additional documentation which is indicated in the PWK segment. Sample versions of the fax/mail cover sheets are attached to CR 7041, which is available at *http://www.cms.gov/Transmittals/downloads/R763OTN.pdf*.
- Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.
- Submitters must send the additional documentation **after** the claim has been electronically submitted with the PWK segment.
- Submitters will need to accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK loop on the claim.
- Medicare contractors will manually return PWK data submissions (cover sheet and attached data) which are incomplete or incorrectly filled out.
- Medicare contractors will allow seven calendar "waiting" days (from the date of receipt) for additional information to be faxed or ten calendar "waiting" days for additional information to be mailed.
- Submitters must send ALL relevant PWK data at the same time for the same claim.
- If the additional documentation is not received within the seven calendar waiting days (fax) or ten calendar waiting days for mailed submissions, your contractor will begin normal processing procedures on your claim.
- Medicare will not crossover PWK data to the coordination of benefits contractor.

## Additional information

If you have questions, please contact your Medicare MAC and/or FI/carrier at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.
The official instruction (CR 7041) issued to your Medicare MAC and/or FI/carrier is available at *http://www.cms.gov/Transmittals/downloads/R763OTN.pdf*.

MLN Matters® Number: MM7041
Related Change Request (CR) #: 7041
Related CR Release Date: August 27, 2010
Effective Date for Providers: April 1, 2011
Related CR Transmittal #: R763OTN
Implementation Date: April 4, 2011



### Use the PDS report to improve your Medicare billing operations

Did you know that the Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Just access the PDS report through our convenient online portal, establish your account, and compare your billing patterns with those of similar providers during a specified billing period. This invaluable resource will help you proactively reduce billing errors by learning to avoid them before they occur. Would you like to find out more? Just visit our dedicated PDS page, where you'll find helpful simulations, a quick-start guide, and a helpful guide to teach you how to apply PDS results to your business needs.

# General Information

## Use Internet-based PECOS for your Medicare enrollment actions

Have you tried Internet-based PECOS for your Medicare enrollment actions? Try it today. It's easy to use and offers a host of advantages over the paper-based enrollment process.

Want more control over your enrollment information? The Internet-based provider enrollment, chain and ownership system (PECOS) does that. Learn how to use the system by selecting the appropriate instructions below based on the type of provider.

## Physicians and nonphysician practitioners

Want more control when adding or changing a reassignment of benefits? Internet-based PECOS does that, too!

**Using Internet-based PECOS is easy**

Learn how to use the system by reading the *Medicare Physician and Non-Physician Practitioner Getting Started Guide*, available at *http://www.cms.gov/MedicareProviderSupEnroll/downloads/GettingStarted.pdf*. And if you encounter problems or have questions as you navigate the system, there is help available at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/ContactInformation.pdf*.

Don't wait, set your practice free from paper – start using Internet-based PECOS today at *http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage*.

## Provider and supplier organizations

Want more control when adding or changing a location or changing ownership information? Internet-based PECOS does that, too!

**Using Internet-based PECOS is easy**

Learn how to use the system by visiting the *Getting Started Guide for Provider and Supplier Organization* at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/OrganizationGettingStarted.pdf*. Remember, the process by which an organization provider can use Internet-based PECOS may take several weeks. It is recommended that you begin this process (if you have not already) well in advance of any upcoming enrollment actions. For more information on this setup process, read the *Provider and Supplier Organization Overview* at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/OrganizationOverview.pdf*.

Don't wait, set your organization free from paper – start using Internet-based PECOS today at *http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage*.

**Note:** Internet-based PECOS is not yet available for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The system will be available for use by DMEPOS suppliers later this year.

**Note:** If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201008-43, 201008-44

## Just released – how to protect your identity using PECOS

### Updates from the *Medicare Learning Network* (*MLN*)

If you are enrolled, or plan to enroll in Medicare, it is important that you protect your Medicare identity from getting into the hands of dishonest and unscrupulous people – personal identity thieves and those intending to commit fraud in the Medicare program.

The Centers for Medicare & Medicaid Services (CMS) has developed "How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)" as the next in a series of Medicare enrollment fact sheets. This fact sheet provides step-by-step instructions to help fee-for-service (FFS) providers protect their identity in Internet-based PECOS and is available in downloadable format on the CMS website at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_ProtID_FactSheet_ICN905103.pdf*.

Stay tuned for updates from the *Medicare Learning Network* as future installments of fact sheets designed to educate FFS providers about important Medicare enrollment information are released.

**Note:** If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201009-10

## Workshop on issues related to accountable care organizations

### Updates from the Medicare Learning Network (MLN)

On October 5, the Federal Trade Commission (FTC) co-hosted a workshop on several issues associated with accountable care organizations (ACOs). The ACOs are authorized by the new Affordable Care Act, which seeks to deliver high-quality and efficient health care services to consumers. Joining the FTC in hosting the event were the Centers for Medicare & Medicaid Services (CMS) and the Department of Health & Human Services' Office of Inspector General.

The workshop, which was held at CMS headquarters in Baltimore, Maryland, was free and open to the public. To facilitate providers' efforts to develop ACOs that will provide high quality, lower-cost care to their patients, the workshop addressed and solicited public comments on the legal issues raised by various ACO models being considered by health care providers. Physicians, physician associations, hospitals, health systems, payers, consumers, and other interested parties were invited to participate in the workshop.

The agencies will publish a *Federal Register* notice shortly that will include a more in-depth explanation of the topics covered during the day-long workshop, including the antitrust, physician self-referral, anti-kickback, and civil monetary penalty laws related to ACOs.

The FTC works for consumers to prevent fraudulent, deceptive, and unfair business practices and to provide information to help spot, stop, and avoid them. To file a complaint in English or Spanish, visit the FTC's online complaint assistant at *https://www.ftccomplaintassistant.gov/*, or call 1-877-FTC-HELP (1-877-382-4357).

The FTC enters complaints into Consumer Sentinel, a secure, online database available to more than 1,800 civil and criminal law enforcement agencies in the United States and abroad. The FTC's website provides free information on a variety of consumer topics at *http://www.ftc.gov/consumer*.

**Note:** If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201009-12

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## CMS makes information about physician fee schedule payment rates more accessible

The physician fee schedule lookup tool (*http://www.cms.gov/apps/physician-fee-schedule/overview.aspx*) was designed to provide information on the payment rate for services by physicians and nonphysician practitioners under the Medicare physician fee schedule (MPFS). The fee schedule lookup includes more than 10,000 physician services, the associated relative value units, a fee schedule status indicator, and various payment policy indicators needed for payment adjustment. With the fee schedule lookup, the user can find not only the national unadjusted payment rate for each service, determined by multiplying the total relative value units assigned to the service by the appropriate conversion factor, but also the geographically adjusted payment rates for each payment locality.

The Centers for Medicare & Medicaid Services (CMS) has now updated and enhanced the fee schedule lookup to allow the user to:

- Download search results into a CSV file
- Modify search criteria without starting over
- Search on all available types of information at the same time (pricing information, payment policy indicators, relative value units, and geographical practice cost index), and
- Sort and view results table columns in ascending or descending order.

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**Source:** CMS PERL 201009-15

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## Four states to receive matching funds for EHR incentive program

In another key step to further states' role in developing a robust U.S. health information technology (HIT) infrastructure, the Centers for Medicare & Medicaid Services (CMS) announced additional federal matching funds for certain state planning activities necessary to implement the electronic health record (EHR) incentive program established by the American Recovery and Reinvestment Act of 2009 (Recovery Act).

EHRs will improve the quality of health care for the citizens of the recipient states and Puerto Rico and make their care more efficient.

The records make it easier for the many providers who may be treating a Medicaid patient to coordinate care. Additionally, EHRs make it easier for patients to access the information they need to make decisions about their health care.

The releases highlight awards (totaling $6.91 million) of 90 percent federal matching funds for planning activities for the Recovery Act's Medicare and Medicaid Electronic Health Record Incentives Programs.

This batch is part of a rolling announcement CMS began in November 2009. To date, including these new announcements, CMS has awarded a total of $81.44 million to 49 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

| Recipient | Award amount |
|---|---|
| North Dakota | $226,000 |
| Hawaii | $836,000 |
| Ohio | $2.29 million |
| Massachusetts | $3.56 million |
| **Subtotal** | $6.91 million |
| **Total awards to date** | $81.44 million |

Additional information on implementation of the Medicaid and Medicare related provisions of the Recovery Act's EHR incentive payment programs may be found at *http://www.cms.gov/EHRIncentivePrograms/*.

The press releases, dated September 13, are available at *https://www.cms.gov/apps/media/press_releases.asp*.

**Note:** If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201009-21

## Key step in national initiative toward adoption of electronic health records

The Certification Commission for Health Information Technology (CCHIT), Chicago, Ill. and the Drummond Group Inc. (DGI), Austin, Texas, were named by the Office of the National Coordinator for Health Information Technology (ONC) as the first technology review bodies that have been authorized to test and certify electronic health record (EHR) systems for compliance with the standards and certification criteria that were issued by the U.S. Department of Health & Human Services earlier this year.

Announcement of these ONC-authorized testing and certification bodies (ONC-ATCBs) means that EHR vendors may now begin to have their products certified as meeting criteria to support meaningful use, a key step in the national initiative to encourage adoption and effective use of EHRs by America's health care providers.

Applications for additional ONC-ATCBs are also under review.

Certification of EHRs is part of a broad initiative undertaken by Congress and President Obama under the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was part of the American Recovery and Reinvestment Act (ARRA) of 2009. HITECH created new incentive payment programs to help health providers as they transition from paper-based medical records to EHRs. Incentive payments totaling as much as $27 billion may be made under the program. Individual physicians and other eligible professionals can receive up to $44,000 through Medicare and almost $64,000 through Medicaid.

Hospitals can receive millions.

For the complete press release, go to Initial EHR Certification Bodies Named at *http://www.hhs.gov/news/press/2010pres/08/20100830d.html.*

For more information about the ONC certification programs visit http*://healthit.hhs.gov/*certification.

For information about the Medicare and Medicaid incentive programs, visit *http://www.cms.gov/EHRincentiveprograms/*.

**Note:** If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

**Source:** CMS PERL 201009-03

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# What's new with PQRI

## New section added to the Physician Quality Reporting Initiative Web page

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the new "How to Get Started" section for participating with the Physician Quality Reporting Initiative (PQRI) program, is available on PQRI Web page. The new section may be found at *http://www.cms.gov/PQRI/03_How_To_Get_Started.asp*.

## 2010 PQRI first quarter quality-data code submission error report by specialty

CMS is pleased to announce the first quarter quality-data code submission error report by Specialty for January 1-March 31, 2010. This report is available on the PQRI Web page and may be downloaded at *http://www.cms.gov/PQRI/Downloads/1Q_2010QDCSubErrorRptbySpecialty07272010_08122010.pdf*.

## Payment adjustment for newly incentive eligible professionals for the 2008 PQRI

CMS is pleased to announce that information on payment adjustments for newly incentive eligible professionals for the 2008 PQRI program is posted in the Spotlight section of the PQRI Web page at *http://www.cms.gov/PQRI*.

Upcoming incentive payment distributions-payment adjustment for newly incentive eligible professionals for the 2008 PQRI after incorporation of the allowed charges requirement:

- Distribution of this additional 2008 incentive, for those newly incentive eligible, begins August 25, 2010, and ends September 17, 2010 (late August through mid September).
- There is a total of 889 tax identification number/national provider identifiers (TIN/NPIs) who were not incentive eligible in the 2008 PQRI program but who are newly incentive eligible after incorporation of the allowed charges requirement.

**Note:** If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201009-01

# What's new with the Electronic Prescribing Incentive program

## New section added to the Physician Quality Reporting Initiative (PQRI) Web page

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the new "How to Get Started" section for participating with the Electronic Prescribing Incentive (eRx) program. The new section may be found at *http://www.cms.gov/ERxIncentive/03_How_To_Get_Started.asp*.

**Note:** If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201008-47

## Use the PDS report to improve your Medicare billing operations

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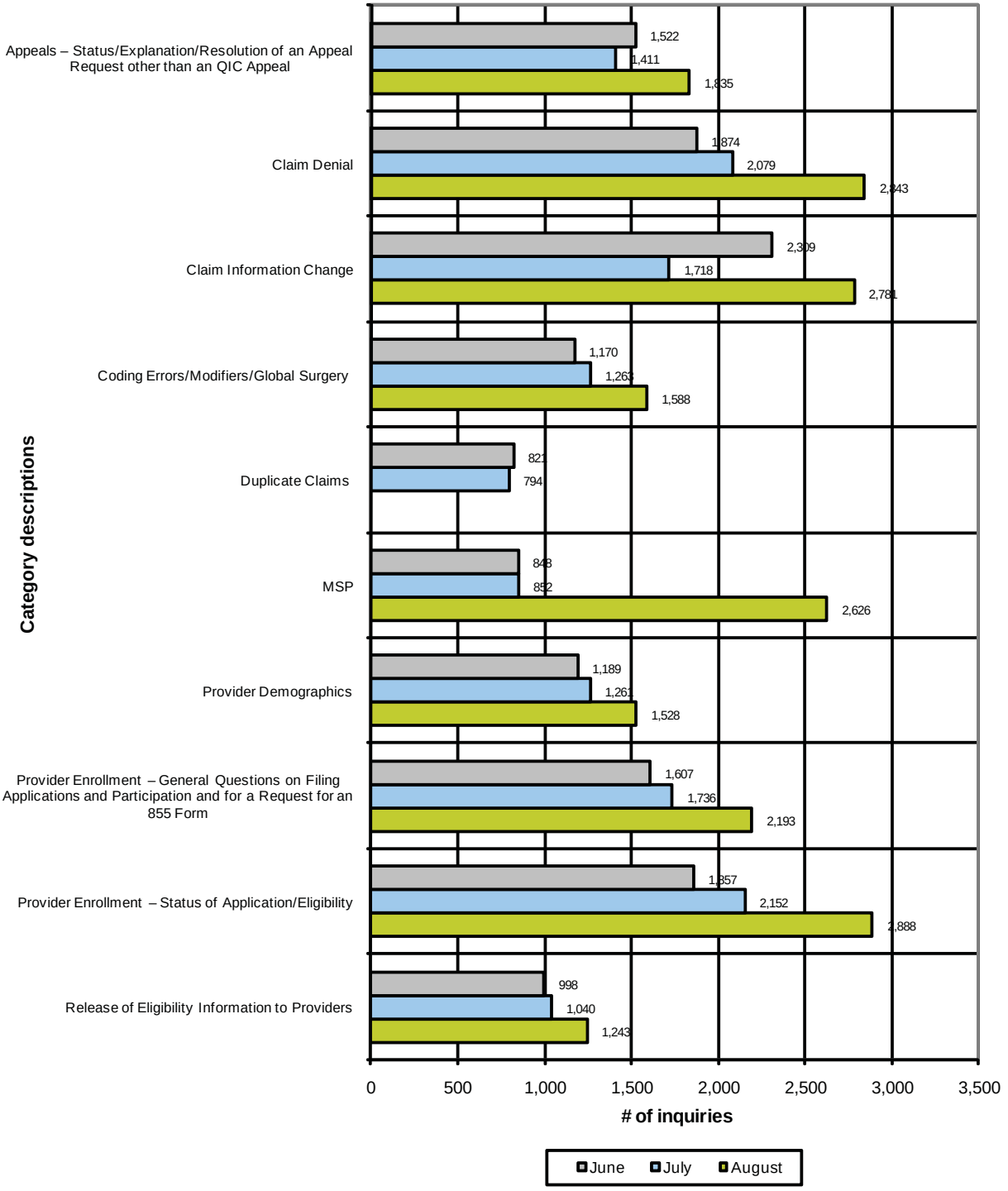
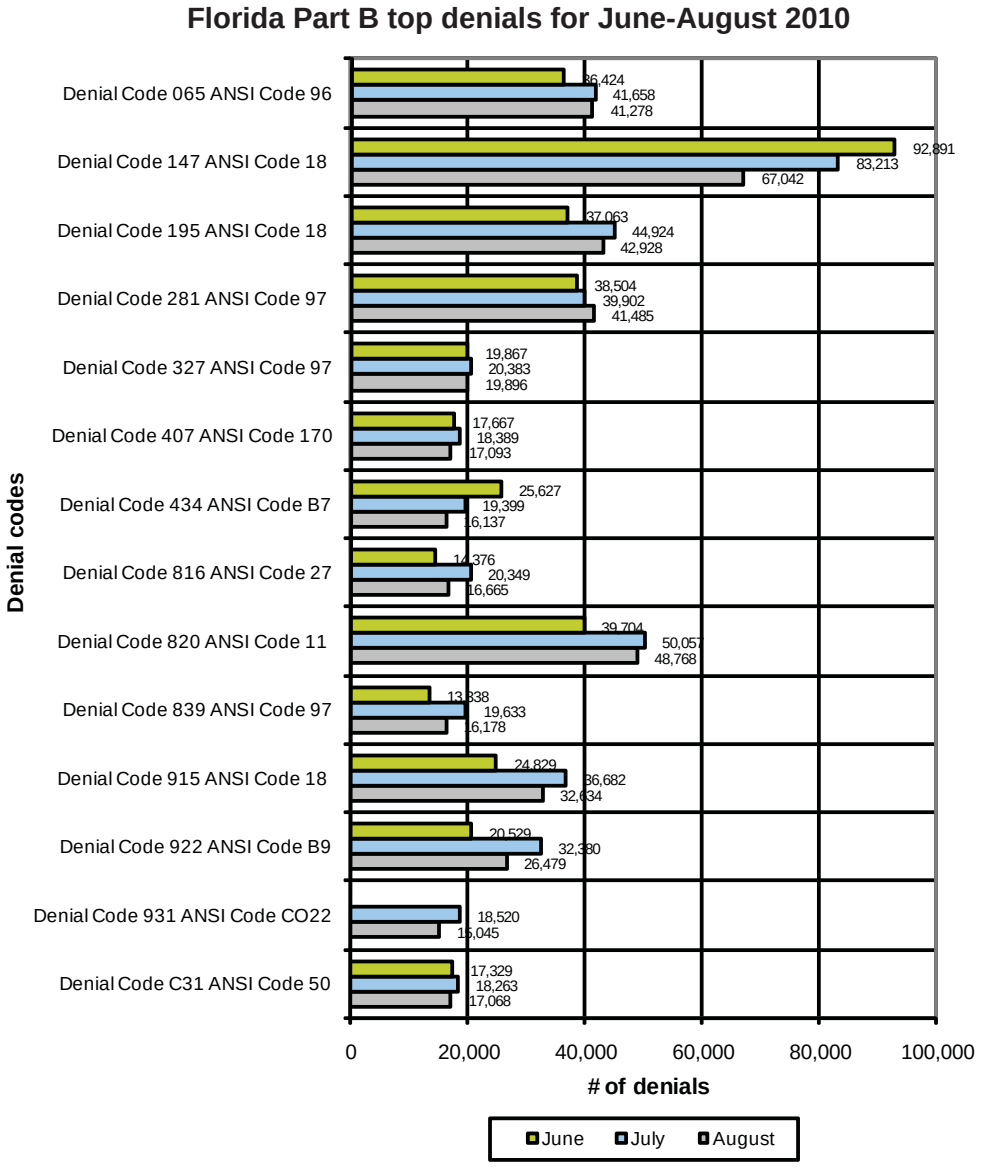
## Top inquiries, denials, and return unprocessable claims for June-August

The following charts demonstrate the top inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Islands providers during June-August 2010. For tips and resources to help you avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

**Florida Part B top inquiries for June-August 2010**



***Top inquiries, denials, and return unprocessable claims for June-August (continued)***




## Tips for avoiding duplicate denials

Before resubmitting a claim, check claims status through the Part B interactive voice response (IVR) system. Do not resubmit an entire claim when partial payment made; when appropriate, resubmit denied lines only. View frequently-asked questions (FAQs) regarding duplicate claims at *http://medicare.fcso.com/FAQs/138013.asp*.

Regarding evaluation and management (E/M) services, physicians in the same group practice of the same specialty must bill and be paid as though they were a single physician.

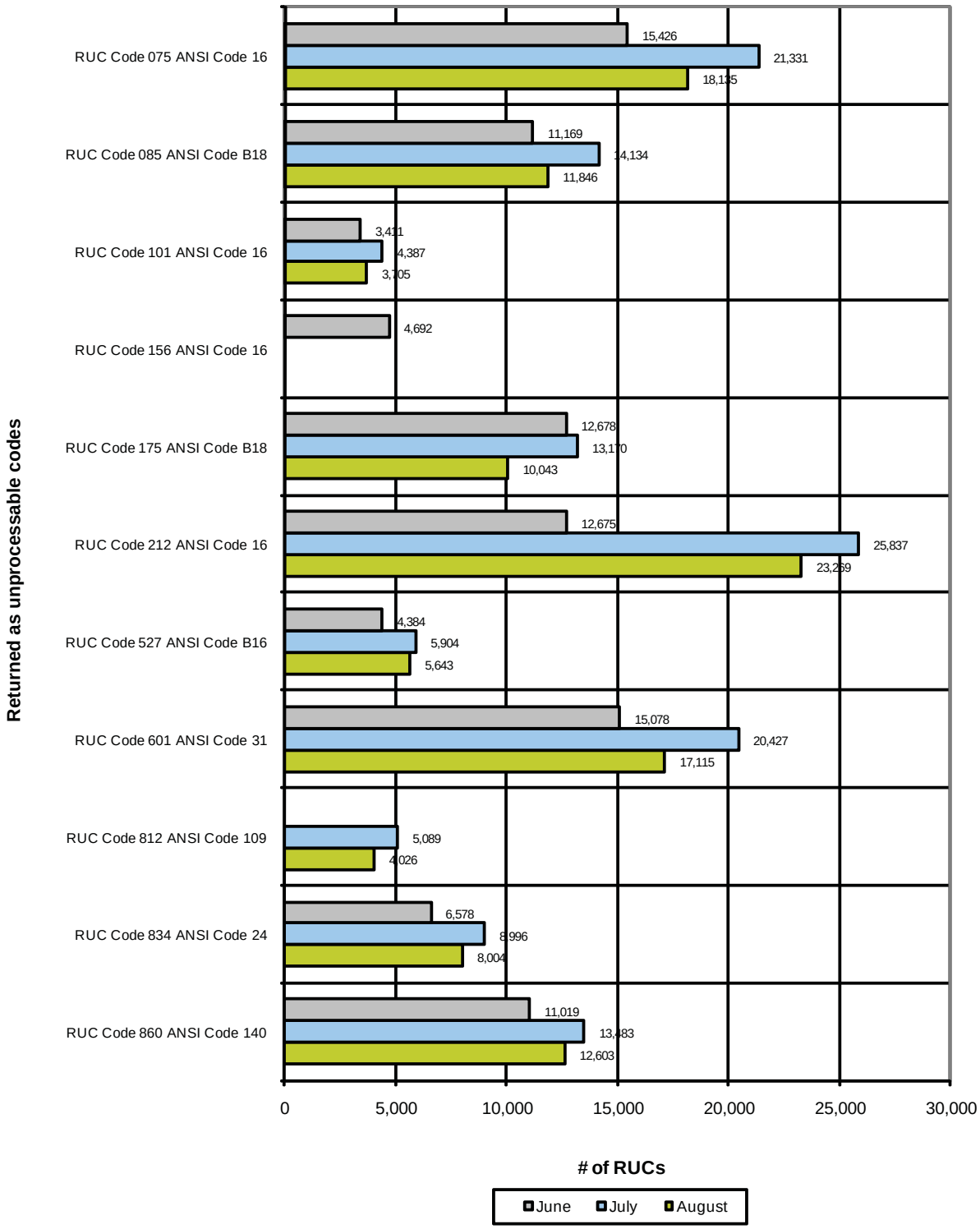
- Only one E/M service may be reported per patient, per day by a physician or by more than one physician of the same specialty in the same group, unless the evaluation and management services are for unrelated problems.
- If more than one face-to-face E/M is provided on the same day to the same patient by the same physician or by more than one physician of the same specialty in the same group, instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.
- Physicians in the same group practice but who are in different specialties (e.g., a cardiologist and a general practice physician) may bill and be paid without regard to their membership in the same group.

FCSO also offers free educational sessions throughout the year, focused on particular billing issues you may be experiencing. These may include webcasts or seminars on avoiding duplicate claims for Part B.

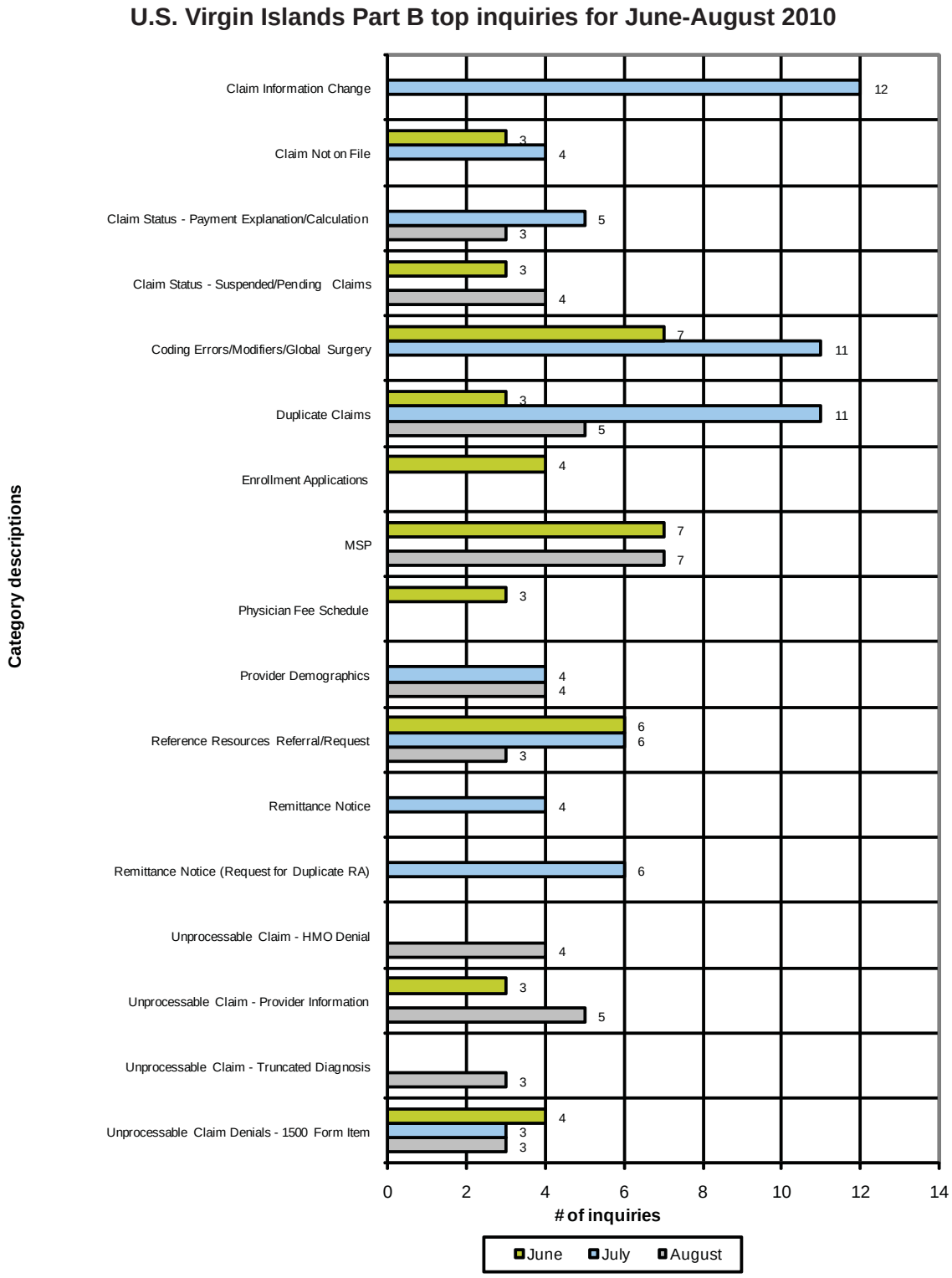
Visit the FCSO Events page at *http://medicare.fcso.com/Events/* to learn about upcoming events and link to our online learning system to review encore presentations of webcasts conducted on this topic.

*Top inquiries, denials, and return unprocessable claims for June-August (continued)*

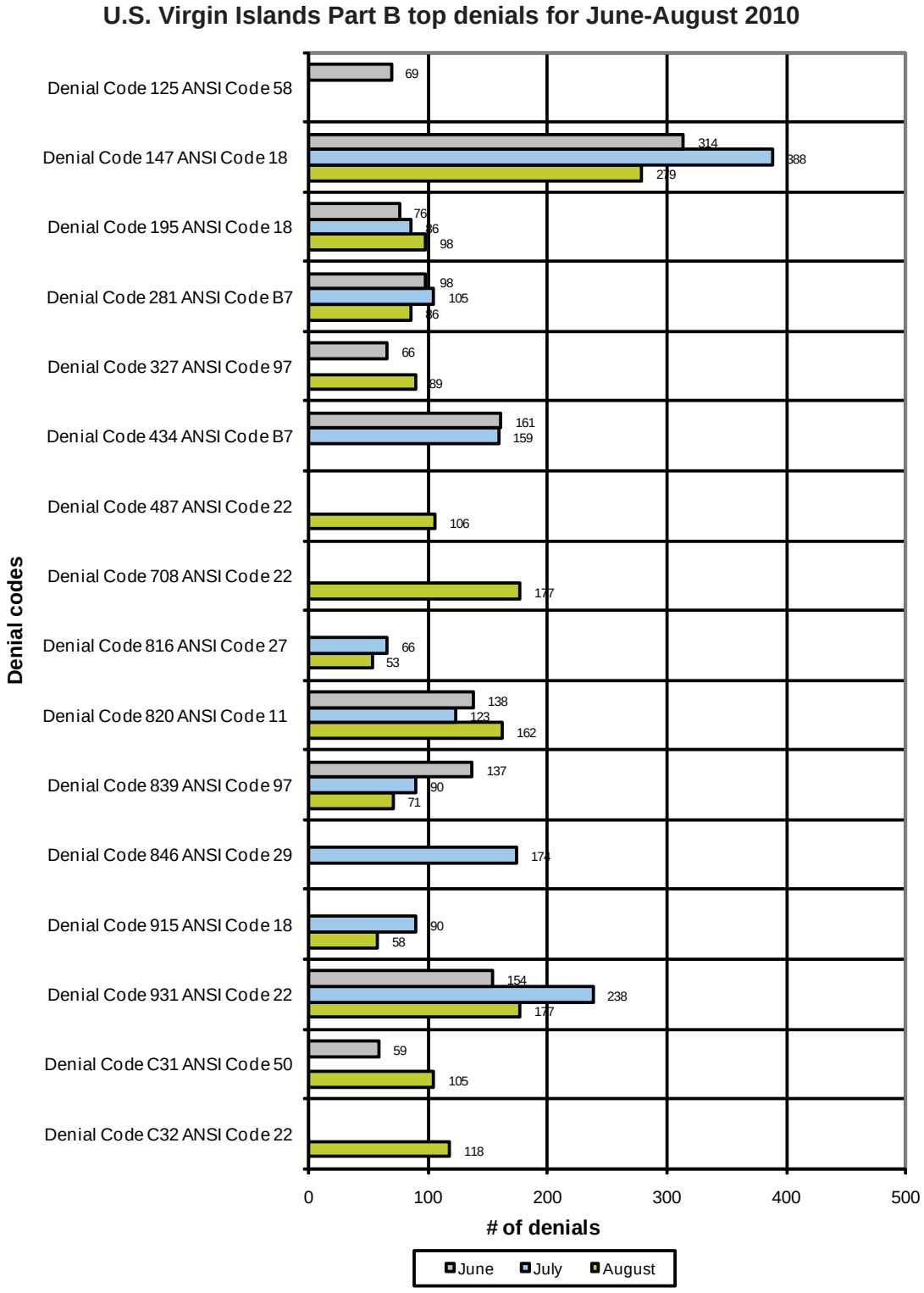
**Florida Part B top return as unprocessable claims (RUC) for June-August 2010**



*Top inquiries, denials, and return unprocessable claims for June-August (continued)*



***Top inquiries, denials, and return unprocessable claims for June-August (continued)***

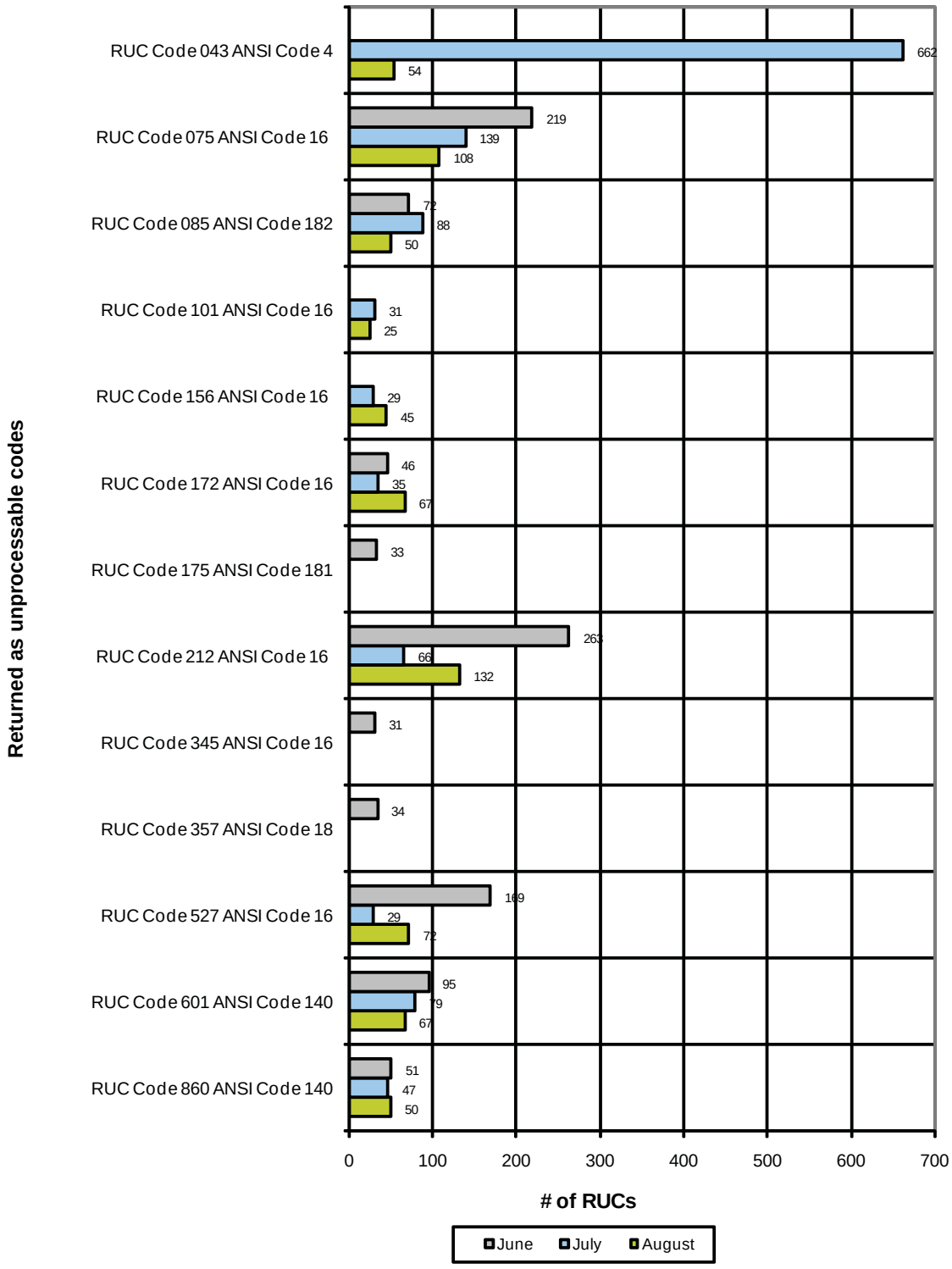



## Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Medicare administrative contractor. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education website. It's very easy to do. Simply go to our website *http://medicare.fcso.com*, click on the "***E-mail***" link located on the upper-right-hand corner of the page and follow the prompts.

*Top inquiries, denials, and return unprocessable claims for June-August (continued)*

**U.S. Virgin Islands Part B top return as unprocessable claims (RUC) for June-August 2010**



# Local Coverage Determinations

This section of the *Medicare B Update!* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier's LCDs and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), contractors no longer include full text local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LCDs are provided instead. Providers may obtain full-text of final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*.

### Effective and notice dates

Effective dates are provided in each LCD, and are based on the date of service (unless otherwise noted in the LCD). Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

### Electronic notification

To receive quick, automatic notification when new LCDs are posted to the website, subscribe to our *FCSO eNews* mailing list. It's very easy to do. Simply go to our website *http://medicare.fcso.com*, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the instructions.

### More information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

**Local Coverage Determinations – Table of Contents**



## Advance beneficiary notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

# Revisions to LCDs

## 2011 ICD-9-CM coding changes

The 2011 update to the ICD-9-CM diagnosis coding structure is effective for services rendered on or after October 1, 2010. Updated diagnosis codes must be used for all services billed on or after October 1, 2010. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Contractors will no longer be able to accept discontinued diagnosis codes for dates of service after the date on which the diagnosis code is discontinued. First Coast Service Options Inc. (FCSO) has reviewed all local coverage determinations (LCDs) for procedure codes with specific diagnosis criteria that are affected by the 2011 ICD-9-CM update. The table on the following pages lists the LCDs affected and the specific conditions revised as a result of the 2011 ICD-9-CM update:

| LCD title | 2011 changes |
|---|---|
| 0171T Interspinous Process Decompression | Removed diagnosis code 724.02 for procedure codes *0171T* and *0172T*.<br>Added diagnosis code 724.03 for procedure codes *0171T* and *0172T*. |
| 27096 Sacroiliac Joint Injection | Changed descriptor for diagnosis code 724.02 for procedure code *27096*.<br>Added diagnosis code 724.03 for procedure code *27096*. |
| 31231 Diagnostic Nasal Endoscopy | Removed diagnosis code 784.52 from diagnosis code range 784.51-784.59 for procedure codes *31231*, *31233*, and *31235* as it is not appropriate.<br>Removed diagnosis code 786.3 for procedure codes *31231*, *31233*, *31235*, and *92511*.<br>Added diagnosis codes 786.30 and 786.39 for procedure codes *31231*, *31233*, *31235*, and *92511*. |
| 31525 Diagnostic Laryngoscopy | Removed diagnosis code 786.3 for procedure codes *31525* and *31575*.<br>Added diagnosis codes 784.92, 786.30, and 786.39 for procedure codes *31525* and *31575*. |
| 43235 Diagnostic and Therapeutic Esophagogastroduodenoscopy | Added diagnosis code 784.52 for procedure codes *43235*, *43236*, *43237*, *43238*, *43239*, *43241*, *43243*, *43244*, *43245*, *43246*, *43247*, *43248*, *43249*, *43250*, *43251*, *43255*, and *43258*. |
| 43644 Surgical Management of Morbid Obesity | Removed diagnosis code V85.4 for procedure codes *43644*, *43645*, *43770*, *43845*, *43846*, and *43847*.<br>Added diagnosis code range V85.41-V85.45 for procedure codes *43644*, *43645*, *43770*, *43845*, *43846*, and *43847*. |
| 44388 Diagnostic Colonoscopy | Removed diagnosis code 787.6 for procedure codes *44388*, *44389*, *44390*, *44391*, *44392*, *44393*, *44394*, *44397*, *45355*, *45378*, *45379*, *45380*, *45381*, *45382*, *45383*, *45384*, *45385*, *45386*, *45387*, *45391*, and *45392*.<br>Added diagnosis code range 787.60-787.63 for procedure codes *44388*, *44389*, *44390*, *44391*, *44392*, *44393*, *44394*, *44397*, *45355*, *45378*, *45379*, *45380*, *45381*, *45382*, *45383*, *45384*, *45385*, *45386*, *45387*, *45391*, and *45392*. |
| 51784 Anorectal Manometry and EMG of the Urinary and Anal Sphincters | Removed diagnosis code 787.6 for procedure codes *51784*, *51785*, and *91122*.<br>Added diagnosis code range 787.60-787.63 for procedure codes *51784*, *51785*, and *91122*. |
| 62263 Endoscopic and Percutaneous Lysis of Epidural Adhesions | Changed descriptor for diagnosis code 724.02 for procedure codes *62263*, *62264*, and *64999*.<br>Added diagnosis code 724.03 for procedure codes *62263*, *62264*, and *64999*. |
| 70540 Magnetic Resonance Imaging of the Orbit, Face, and/or Neck | Added diagnosis code 784.92 for procedure codes *70540*, *70542*, and *70543*. |

***2011 ICD-9-CM coding changes (continued)***

| LCD title | 2011 changes |
|---|---|
| 70544 Magnetic Resonance Angiography (MRA) | Removed diagnosis code 786.3 for procedure codes *71555*, C8909, C8910, and C8911.<br>Added diagnosis codes 786.30 and 786.39 for procedure codes *71555*, C8909, C8910, and C8911. |
| 71275 Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries | Removed diagnosis code 786.3 for procedure code *71275*.<br>Added diagnosis codes 786.30 and 786.39 for procedure code *71275*. |
| 73218 Magnetic Resonance Imaging of Upper Extremity | Added diagnosis codes 237.73, 237.79, and 447.70-447.73 for procedure codes *73218*, *73219*, *73220*, *73221*, *73222*, and *73223*. |
| 82330 Ionized Calcium | Added diagnosis code 780.66 for procedure code *82330*. |
| 84100 Serum Phosphorus | Added diagnosis codes 799.51, 799.52, 799.54, and 799.55 for procedure code *84100*. |
| 86706 Hepatitis B Surface Antibody and Surface Antigen | Added diagnosis code 780.66 for procedure code *87340*. |
| 90901 Biofeedback | Removed diagnosis code 787.6 for procedure code *90911*.<br>Added diagnosis code range 787.60-787.63 for procedure code *90911*. |
| 92081 Visual Field Examination | Added diagnosis codes 237.73 and 237.79 for procedure codes *92081*, *92082*, and *92083*. |
| 93000 Electrocardiography | Removed diagnosis code 276.61 from diagnosis code range 276.0-276.9 for procedure codes *93000*, *93005*, and *93010* as it is not appropriate.<br>Added diagnosis code 276.69 for procedure codes *93000*, *93005*, and *93010*. |
| 93303 Transthoracic Echocardiography (TTE) | Removed diagnosis code 275.0 for procedure codes *93306*, *93307*, and *93308*.<br>Added diagnosis code range 275.01-275.09 for procedure codes *93306*, *93307*, and *93308*. |
| 93312 Transesophageal Echocardiogram | Added diagnosis code 278.03 for procedure codes *93312*, *93313*, *93314*, *93315*, *93316*, *93317*, and *93318*. |
| 93965 Non-Invasive Evaluation of Extremity Veins | Removed diagnosis code 786.3 for procedure codes *93965*, *93970*, and *93971*.<br>Added diagnosis codes 786.30 and 786.39 for procedure codes *93965*, *93970*, and *93971*. |
| 93975 Duplex Scanning | Removed diagnosis code 784.52 from diagnosis code range 784.51-784.59 for procedure codes *93978* and *93979* as it is not appropriate. |
| 95925 Somatosensory Testing | Changed descriptor for diagnosis code 724.02 for procedure codes *95925*, *95926*, and *95927*.<br>Added diagnosis code 724.03 for procedure codes *95925*, *95926*, and *95927*. |
| G0430 Qualitative Drug Screening | Removed diagnosis code 970.8 for procedure codes *80100*, *80102*, G0430, and G0431.<br>Added diagnosis code range 970.81-970.89 for procedure codes *80100*, *80102*, G0430, and G0431. |
| J0470 Chelation Therapy | Removed diagnosis code 275.0 for procedure code J0895.<br>Added diagnosis code range 275.01-275.09 for procedure code J0895. |
| J0800 Corticotropin | Removed diagnosis code 287.4 for procedure code J0800.<br>Added diagnosis code range 287.41-287.49 for procedure code J0800. |
| J0881 Erythropoiesis Stimulating Agents | Changed descriptor for diagnosis code V07.8 for procedure code J0885 (List 1). |
| J2355 Oprelvekin (Neumega) | Removed diagnosis code 287.4 for procedure code J2355.<br>Added diagnosis code 287.49 for procedure code J2355. |
| J2505 Pegfilgrastim (Neulasta) | Changed descriptor for diagnosis code V07.8 for procedure code J2505. |

***2011 ICD-9-CM coding changes (continued)***

| LCD title | 2011 changes |
|---|---|
| J2792 Rho (D) Immune Globulin Intravenous | Removed diagnosis code 999.7 for procedure codes J2788, J2790, J2791, and J2792.<br><br>Added diagnosis code range 999.70-999.79 for procedure codes J2788, J2790, J2791, and J2792. |
| PULMDIAGSVCS Pulmonary Diagnostic Services | Removed diagnosis code 786.3 for procedure codes *93720*, *93721*, *93722*, *94010*, *94060*, *94070*, *94200*, *94240*, *94250*, *94260*, *94350*, *94360*, *94370*, *94375*, *94620*, *94621*, *94720*, *94725*, and *94750*.<br><br>Added diagnosis codes 786.30 and 786.39 for procedure codes *93720*, *93721*, *93722*, *94010*, *94060*, *94070*, *94200*, *94240*, *94250*, *94260*, *94350*, *94360*, *94370*, *94375*, *94620*, *94621*, *94720*, *94725*, and *94750*. |



**Find LCDs faster on our new medical coverage page**

Looking for an LCD? Try the new integrated-search features on our redesigned medical coverage page. You may now search for local coverage determinations (LCDs) by procedure name or code as well as by L number. With its new features and user-friendly layout, you'll also find the medical coverage news and resources you need more quickly and easily than ever before -- try it today. *http://medicare.fcso.com/Landing/139800.asp*.

# Educational Events

## Upcoming provider outreach and educational events
## October 2010

### Avoid procedure-to-diagnosis claim denials

When: Tuesday, October 5
Time: Time: 8:30-9:30 a.m.

### National Correct Coding Initiative (NCCI) and related denials

When: Thursday, October 7
Time: Time: 8:30-9:30 a.m.

### How to avoid duplicate claim denials

When: Wednesday, October 13
Time: Time: 8:00-9:00 a.m.

### HIGLAS transition seminar

When: Wednesday, October 27 (two sessions)
Time: 1:00 p.m. – 2:00 p.m. & 3:00 p.m. – 4:00 p.m.
**Type of event: Face-to-face**
**Focus: U.S. Virgin Islands**

**Note:** Unless otherwise indicated, all FCSO educational offerings are considered to be "ask-the-contractor" events, "webcast" type of event, designated times are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands

### Two easy ways to register

**Online** – Visit our provider training website at *www.fcsomedicaretraining.com*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

**First-time User?** Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

**Fax** – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

### Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____
Registrant's Title: _____
Provider's Name: _____
Telephone Number: _____ Fax Number: _____
E-mail Address: _____
Provider Address: _____
City, State, ZIP Code: _____

Keep checking our Web site, *www.medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the FCSO Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

### Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the FCSO Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

### Take advantage of 24-hour access to free online training

In addition to our live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses now offer CEUs. Learn more on the FCSO Medicare training website and explore our catalog of online courses.

# Preventive Services

## September is Prostate Cancer Awareness Month

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging them to take advantage of Medicare-covered prostate cancer screenings. Medicare provides coverage for digital rectal exams (DREs) and prostate specific antigen tests (PSAs) for qualified beneficiaries.

### What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your Medicare patients by encouraging them to take advantage of Medicare-covered screenings, including prostate cancer screenings that are appropriate for them.

### For more information

CMS has developed several educational products related to Medicare-covered prostate cancer screenings. They are all available, free of charge, from the *Medicare Learning Network*®:

- **The MLN Preventive Services Educational Products Web page** – provides descriptions and ordering information for MLN educational products for health care professionals related to Medicare-covered preventive services, including prostate cancer screening. *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp*
- ***The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals*** – provides coverage and coding information on Medicare-covered preventive services and screenings, including prostate cancer screening. *http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*
- ***Quick Reference Information: Medicare Preventive Services*** – this chart provides coverage and coding information on Medicare-covered preventive services, including prostate cancer screenings. *http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*
- ***The Medicare Preventive Services Series: Part 3 Web-based-training (WBT) course*** – this WBT includes lessons on coverage, coding, and billing for Medicare-covered preventive services, including prostate cancer screenings. To access the course, please visit the MLN home page at *http://www.cms.gov/mlngeninfo* on the Internet. Scroll down to "Related Links Inside CMS" and click on "Web Based Training (WBT) Modules".
- ***The Cancer Screenings brochure*** – this brochure provides information on coverage for Medicare-covered cancer screenings, including prostate cancer screenings. *http://www.cms.gov/MLNProducts/downloads/cancer_screening.pdf*

Please visit the *Medicare Learning Network* for more information on these and other Medicare fee-for-service educational products. For more information on Prostate Cancer Awareness Month, please visit Zero- The Project to End Prostate Cancer at *http://www.zerocancer.org/index.html*.

**Note:** If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201009-08



## September flu shot reminder

Vaccinate early to protect against the flu. The Centers for Disease Control and Prevention (CDC) recommends a yearly flu vaccination as the first and most important step in protecting against flu viruses. Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no co-pay or deductible. This year's vaccine will protect against three different flu viruses, including the H1N1 virus that caused so much illness last flu season. Take advantage of each office visit and start protecting your patients as soon as your 2010-2011 seasonal flu vaccine arrives. And, don't forget to immunize yourself and your staff. Get your flu vaccine – not the flu.

**Remember**: Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is not a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit *http://www.cms.gov/AdultImmunizations*.

**Note:** If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201008-30

# Other Educational Resources

## Updates from the *Medicare Learning Network*

The *Medicare Learning Network* has updated the following provider educational materials:

- The *Advanced Beneficiary Notice of Noncoverage (ABN)* booklet, which provides information on when providers should use an ABN, ABN policies, how to properly complete an ABN and ABN modifiers, is now available in hardcopy format from the *Medicare Learning Network*®. To order your copy, free of charge, please visit the "MLN Products" page on the Internet at *http://www.cms.gov/MLNProducts/01_Overview.asp*. Scroll down to the "Related Links Inside CMS" section and choose "MLN Product Ordering Page". To view the online version, please visit on the Internet *http://www.cms.gov/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf*.
- The publication titled *The Medicare Overpayment Collection Process* (previously titled *What Physicians and Other Suppliers Should Know About Medicare Overpayments*), which provides the definition of an overpayment and information about the collection of Medicare physician and supplier overpayments, is now available in downloadable format from the *Medicare Learning Network*® at *http://www.cms.gov/MLNProducts/downloads/OverpaymentBrochure508-09.pdf*.

**Note:** If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201009-17

## Audio transcript of the September 13 ICD-10 follow-up conference call

The audio transcript is available for the September 13 Centers for Medicare & Medicaid Services' (CMS) follow-up national provider conference call, "ICD-10 Implementation in a 5010 Environment." The audio transcript may be accessed at *http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp*. Scroll to the bottom of the Web page to the *Downloads* section to locate the audio file. The audio transcript is approximately one hour and 28 minutes in length. The written transcript will be available soon.

**Note:** If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201009-29

# Mail directory

## Claims submissions

**Routine paper claims**
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

**Participating providers**
Medicare Part B participating providers
P. O. Box 44117
Jacksonville, FL 32231-4117

**Chiropractic claims**
Medicare Part B chiropractic unit
P. O. Box 44067
Jacksonville, FL 32231-4067

**Ambulance claims**
Medicare Part B ambulance dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

**Medicare secondary payer**
Medicare Part B secondary payer dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

**ESRD claims**
Medicare Part B ESRD claims
P. O. Box 45236
Jacksonville, FL 32232-5236

## Communication

**Redetermination requests**
Medicare Part B claims review
P.O. Box 2360
Jacksonville, FL 32231-0018

**Fair hearing requests**
Medicare hearings
P.O. Box 45156
Jacksonville FL 32232-5156

**Freedom of Information Act**
Freedom of Information Act requests
Post office box 2078
Jacksonville, Florida 32231

**Administrative law judge hearing**
Q2 Administrators, LLC
Part B QIC South Operations
P.O. Box 183092
Columbus, Ohio 43218-3092
Attn: Administration manager

**Status/general inquiries**
Medicare Part B correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

**Overpayments**
Medicare Part B financial services
P. O. Box 44141
Jacksonville, FL 32231-4141

## Durable medical equipment (DME)

**DME, orthotic or prosthetic claims**
Cigna Government Services
P.O. Box 20010
Nashville, Tennessee 37202

## Electronic media claims (EMC)

**Claims, agreements and inquiries**
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

## Additional development

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

**Over 40 days of initial request: Submit the charge(s) in question, including information requested, as you would a new claim, to:**
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

## Miscellaneous

Provider participation and group membership issues; written requests for UPINs, profiles & fee schedules:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

**Provider change of address:**
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

## Provider education

**Educational purposes and review of customary/prevailing charges or fee schedule:**
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

**Education event registration:**
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

**Limiting charge issues:**
**Processing errors:**
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

**Refund verification:**
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

**Medicare claims for Railroad retirees:**
Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

**Fraud and abuse**
First Coast Service Options Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

# Phone numbers

## Providers

**Toll-Free**
**Customer Service:**
1-866-454-9007

**Interactive Voice Response (IVR):**
1-877-847-4992

**E-mail address:** *AskFloridaB@fcso.com*

**FAX**: 1-904-361-0696

### Beneficiary

**Toll-Free:**
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

**Note**: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

## Education event registration (not toll-free):

1-904-791-8103

## Electronic data interchange (EDI)

1-888-670-0940

**Option 1** -Transaction support

**Option 2 -** PC-ACE support

**Option 4 -** Enrollment support

**Option 5 -** Electronic funds (check return assistance only)

**Option 6 -** Automated response line

## DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

## Medicare Part A

Toll-Free:
1-866-270-4909

# Medicare websites

## Provider

First Coast Service Options Inc. (FCSO), your CMS-contracted Medicare administrative contractor
*http://medicare.fcso.com*

**Centers for Medicare & Medicaid Services**
*www.cms.gov*

## Beneficiaries

**Centers for Medicare & Medicaid Services**
*www.medicare.gov*

# Mail directory

### Claims, additional development, general correspondence

**First Coast Service Options Inc.**
P. O. Box 45098
Jacksonville, FL 32232-5098

### Flu rosters

**First Coast Service Options Inc.**
P. O. Box 45031
Jacksonville, FL 32232-5031

### Electronic data interchange (EDI)

**First Coast Service Options Inc.**
P. O. Box 44071
Jacksonville, FL 32231-4071

### Part B debt recovery, MSP inquiries and overpayments, and cash management

**First Coast Service Options Inc.**
P.O. Box 45013
Jacksonville, FL 32232-5013

### Provider enrollment

**Where to mail provider/supplier applications**
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

**Provider change of address**
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

and

Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109

### Redeterminations

**First Coast Service Options Inc.**
P. O. Box 45024
Jacksonville, FL 32232-5091

### Redetermination overpayment

**First Coast Service Options Inc.**
P. O. Box 45091
Jacksonville, FL 32232-5091

### Freedom of Information Act requests (FOIA)

**First Coast Service Options Inc.**
P. O. Box 45073
Jacksonville, FL 32232-5073

### Congressional inquiries

**First Coast Service Options Inc.**
Attn: Carla-Lolita Murphyt
P. O. Box 2078
Jacksonville, FL 32231-0048

### Provider education

**Educational purposes and review of customary/prevailing charges or fee schedule:**
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

**Education event registration:**
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

### Medicare claims for railroad retirees

Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

## Fraud and abuse

First Coast Service Options Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

### Local coverage determinations

First Coast Service Options Inc.
P. O. Box 2078
Jacksonville, FL 32231-0048

### Post pay medical review

First Coast Service Options Inc.
P. O. Box 44288
Jacksonville, FL 32231-4288

### Overnight mail and/or other special courier services

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

# Medicare websites

### Provider

First Coast Service Options Inc. (FCSO), your CMS-contracted Medicare administrative contractor
*http://medicare.fcso.com*

### Centers for Medicare & Medicaid Services

*www.cms.gov*

### Beneficiaries

**Centers for Medicare & Medicaid Services**
*www.medicare.gov*

# Phone numbers

### Provider customer service

1-866-454-9007

### Interactive voice response (IVR)

1-877-847-4992

**E-mail address:** *AskFloridaB@fcso.com*

**FAX**: 1-904-361-0696

### Beneficiary customer service

1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

**Note**: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

### Education event registration

1-904-791-8103

### Electronic data interchange (EDI)

1-888-670-0940

**Option 1** -Transaction support

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**Option 6** - Automated response line

### DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

### Medicare Part A

Toll-Free:
1-866-270-4909

## Order form for Medicare Part B materials

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to FCSO Account # (use appropriate account number). Do not fax your order; it must be mailed.

**Note**: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

| Item | Acct Number | Cost per item | Quantity | Total cost |
|---|---|---|---|---|
| **Part B subscription** – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2010 through September 2011. | 40300260 | Hardcopy $33 | | |
| | | CD-ROM $55 | | |
| **2010 Fee Schedule –** The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through May 31, 2010, and June 1 through November 30, 2010, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies or a CD-ROM are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publications. | 40300270 | Hardcopy $12 | | |
| | | CD-ROM $6 | | |
| Language preference: **English** [ ] **Español** [ ] | | | | |
| | | ***Please write legibly*** | Subtotal | $ |
| | | | Tax (***add % for your area***) | $ |
| | | | Total | $ |

**Mail this form with payment to:**

**First Coast Service Options Inc.**
**Medicare Publications**
**P.O. Box 406443**
**Atlanta, GA 30384-6443**

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

***(Checks made to "purchase orders" not accepted; all orders must be prepaid)***

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

# *MEDICARE B Update!*

*First Coast Service Options Inc.*
*P.O. Box 2078  Jacksonville, FL.  32231-0048*

**♦ ATTENTION BILLING MANAGER ♦**